THE AMERICAN JOURNAL of OCCUPATIONAL THERAPY

CIAL PUBLICATION OF THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

II, No. 2 1948 April

W. L. West

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ANNUAL

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ew York, N. Y.

pt. 4-6, 1948

APRIL

1948

Published Bi-monthly for the American Occupational Therapy Association by AJOT Publishing Co., Boston 16.

THE AMERICAN JOURNAL OF OCCUPATIONAL THERAPY, April 1948. Published bi-monthly by the American Occupational Therapy Association, AJOT Publishing Co., 126 Dartmouth Street, Boston 16, Mass. Entered as Second Class Matter at Post Office at Boston, Mass., March 12, 1947 under the Act of March 3, 1879. Subscription rate, $5.00 a year; $1.00 per single copy.

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THE AMERICAN JOURNAL

of

OCCUPATIONAL THERAPY

Official Publication of the American Occupational Therapy Association

VOL. II, NO. 2 APRIL 1948

Some Aspects of the Role of Psychiatry in Contemporary Society

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Speech delivered at the annual meeting of the American Occupational Therapy Association, San Diego, California, November 3, 1947.

I know relatively little about the field of occupational therapy except in the general way in which a specialist in one field is acquainted with the material of a related field of specialization. However, since much of your work is done in relation to psychiatric patients, you are properly interested in and concerned with the broad field of psychiatry as a whole. Much of the program of your convention will deal with the practical application of your specialty to psychiatric patients. As I understand it, one of the main purposes of my speaking to you, is to deal with the over-all aspects of psychiatry rather than its particular applications.

I, therefore, chose as my topic the problem of some of the relations of the psychiatrist to our society. I shall approach this problem first from the historical point of view, briefly tracing the development of psychiatry in the last several decades, and then try to relate this historical aspect to the social forces at work during this period. Following this, I shall attempt to briefly present and illustrate the basic conceptions of modern dynamic psychiatry. From these two aspects, I shall then delimit what appears to me to be the role of the psychiatrist in our present day society.

Before the first World War psychiatry led a cloistered existence, confined mostly behind institutional walls. Psychiatrists devoted most of their time to the institutional care of psychotic patients. Little could be done beyond pinning a diagnosis on a patient and assigning him to a ward for care. Therapeutic efforts were practically nil, or at best, sporadic and without much direction, goal or underlying principle. Institutions were for the most part located relatively far from populated centers, so that not only were the patients, but frequently the psychiatrists also, institutionalized. This physical isolation of the institutions led to the isolation of the psychiatrists from the general life of the community and from the main stream of medicine. The advances of general medicine were little reflected within the walls of the psychiatric institutions. This formal psychiatry, concerned primarily with diagnostic problems in psychotic individuals, did not arouse much interest in the public mind. However, one branch of psychiatry, namely

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psychoanalysis, had begun to demand public attention by its concern with psychological phenomena which directly affected the lives of large numbers of people. But before the first World War, even this field had not captured the public fancy.

With the end of the first World War psychiatry began to grow. Public attention began to centre more and more upon it. People became aware of the fact that relatively large numbers of men were in one way or another incapable of adjusting to army life and yet showed no signs of organic disorder. Following the termination of hostilities, many soldiers had great difficulty in readjusting to civilian life. Two explanations were popularly accepted for such cases: shell shock or gassing. In some mysterious way the concussion of the shells was supposed to have caused some definite change in the central nervous system, which resulted in the various nervous disorders which were evident. Equally mysterious was the action of poison gas on the nervous system. Both medicine and formal psychiatry tended to accept these facile explanations, which in reality explained nothing.

However, it was not only among ex-soldiers that neurotic disorders appeared, but in the civilian population as well. Probably as a result of the inevitable disruption of the established ways of life, accelerated by the war conditions, which reflected deep going social and economic changes in our society, neurotic disorders tended to increase, or at least were acknowledged more readily. In addition, the ideas of Freud and his followers, which for the first time offered some scientific rational explanation of neurotic disorders, began to make an impression upon both the medical profession and the public mind. Psychiatry split into two segments. Formal psychiatry continued its rather cloistered existence, while dynamic psychiatry plunged into the hurly-burly of real life.

Between the first and the second World Wars, dynamic psychiatry grew slowly and steadily in importance. Both the public and the field of general medicine paid more and more attention to it. Periodicals in increasing numbers printed articles about psychiatry. Unfortunately, all too frequently these were of a sensational character. Intellectuals read the works of the Freudian school and adopted its terminology. With the coming of the depression, efforts were made to utilize this increasing popularity of psychiatric knowledge to explain away the very real problems of existence faced by large numbers of people. Institutional psychiatry did not escape the effects of this crisis. Many individuals who had previously been able to adjust at a borderline level were unable to face the severe competition and were forced into institutions, either because they were unable to support themselves, or because their families could no longer support them. These included many senile individuals, borderline mental defectives, etc. Great overcrowding resulted, aggravated by budget cuts and the resultant inadequate provisions for the care of the institutionalized patient.

But there is an additional interesting reason for the great increase in interest in psychological problems during the years of the depression. This is an important ideological premise in our society, namely, what is popularly called "rugged individualism." In our social system, with its fiercely individualistic competitive attitude, failure on the part of the individual is considered his own personal responsibility. An extremely high premium is placed on economic success, and social prestige rests to a great extent on this basis. Because of the high premium which is placed on the role of the individual, failure cannot be attributed to social conditions beyond the control of the individual. Intellectually, many people were able to see that external social factors which were beyond their control, played a large role in their personal failures. They were, therefore, able to work with others equally affected in an attempt to better conditions. But emotionally, the burden of personal failure was felt as a reflection of some inner weakness or defect. This resulted in severe conflicts, emotional disturbances, anxiety and neurotic symptoms. People sought for some explanation and help for the inner turmoil which they experienced.

Formal psychiatry, with its static diagnostic approach, offered little solace in this regard. But dynamic psychiatry, dynamic psychology, did present explanations and offer help for the conflicts, worries, difficulties, and problems with which people were beset. People became of necessity more aware of themselves and what was going on within them than ever before. Pressed by severe external conditions, conflicts

and doubts rose more easily to the surface. Irrational fears, anxiety in relation to one's self and one's family and friends, hostile feelings towards the world increased under this stress. All this created marked feelings of insecurity in the individual. The depth and severity of the depression created great dislocations in our social structure. No one could feel secure about his place in society, particularly if measured in financial terms. With the cultural stress still upon the 'success in spite of all obstacles' tradition, and with the opportunities to reach the top markedly restricted and diminished, great feelings of personal inadequacy were engendered. The boisterous self-confidence of the business men's clubs began to sound to many like hollow breast-beating. It did not ring true in face of the hard, harsh reality of the depression with jobless and 'no help wanted' signs everywhere.

And, for the first time, a science attempted to cope with the problem of these feelings which so many individuals now had to face. They could no longer be dismissed as 'weakness' or 'lack of moral courage,' or by means of any other superficial catch phrases. People wanted to know and understand themselves and what was happening within them. Dynamic psychiatry attempted to show them some of the answers. And because its principles were valid and it had something to offer, it grew and gained ascendancy.

In the course of the second World War, dynamic psychiatry met its greatest test—perhaps too great a test for so young a science. But, faced with the problem of a tremendous number of neuropsychiatric disorders in the armed forces, it was far better able to approach its task than was formal psychiatry. It attempted to acquaint large groups of people, both in the armed forces and in civilian life, with simple, practical, useful, psychological facts, to dispel many psychological misconceptions, and to deal constructively with the emotional difficulties created by the sudden disruption of life engendered by the war. That it succeeded to a certain extent is evidenced by its great popularity at the present time. But this very popularity has its dangers. There is a tendency to overevaluate psychiatry, to look to it for the answers to all types of individual and social problems, to demand of it more than it is able to give. Psychiatry, at its present level of development, does not have an answer for all our ills.

Psychiatry is a science which deals with individuals who are emotionally disturbed in their interpersonal relations and in relation to their environment. It is a science of the individual. It is always dangerous to take the methodology and conclusions reached in one scientific field and apply them to another. Of course, psychiatry meets with general social problems in its treatment of the individual patient but it deals with them as they affect the individual. But social problems exist outside of the individual. To take what we have learned through the study of particular individuals and use these facts to explain social conditions appears to me to be a dangerous procedure, unless it is done with great caution and discrimination. For example, to conclude that German culture is a 'paranoid culture' because it presents certain parallels to the psychological structures found in paranoid individuals, appears to me unjustified. There may be a grain of truth in this facile conclusion, just enough to make us tend to overlook the objective social and economic factors which led to the formation of the nationalistic militaristic attitude in Germany, culminating in the development of the Nazi Movement. It is just as dangerous and fallacious to attempt to explain what is going on in China today on the basis of a mystical 'oriental character.' If, for example, the Chinese were to say that we act as a nation because of an 'inscrutable American character' formed by the influence of the aboriginal Indian inhabitants of this continent, we would dismiss this as ridiculous tommyrot. Yet, we find such glib statements applied to other cultural groups, propounded with an air of solemnity and finality, as if thereby everything were clearly explained.

There exists a very real external world. There are not only psychological facts, but physical and sociological forces as well. These forces exert a definite influence upon individuals. Not everything can be explained on a psychological basis alone.

If I seem to lay so much emphasis on this point, it is merely to counteract the tendency to overemphasize subjective factors, to apply what we have learned about the psychology

of the individual too indiscriminately to society as a whole.

The substance of what I have been saying may be summed up in a general way as follows: There is a certain hierarchy among sciences, which is conditioned by the complexity of the organization of the material with which it is dealing. While the concepts of a more complex science may not contradict those of the other sciences upon which it is based, the material of this science cannot be explained fully or completely in terms of these more basic sciences alone. Thus, biological concepts cannot contradict physical or chemical facts, but these latter, in themselves, are insufficient to explain biological phenomena. So, also sociological concepts must be consistent with psychological facts, but again these latter alone are inadequate to explain or encompass social phenomena.

But, before going further along this line, I should like to return to a train of thought which I interrupted earlier. The psychological impact of the profound and enormous changes which have occurred in our mode of existence has not yet been really fully evaluated. Perhaps this is due to the fact that we are all still too close to these changes. I am referring in particular to two things which we take so much for granted today, that it is hard to conceive of a world without them, namely, electricity and the gasoline engine. Man, it is true, molds and transforms his environment, but we often forget, or tend to neglect, the fact that this transformed environment in its turn molds and transforms the individual. It is only in recent years that man has become independent to a great extent of the light of the sun. Of course, we still have night and day, but the sharp dichotomy between light and darkness has been markedly diminished by the strength and power of the electric light. Our lives have been expanded greatly by this power which we have gained.

For the first time in history, man has freed himself to a certain extent from his dependence on daylight, from the rhythm to which all other animals are inexorably subject. With the introduction of electricity in our homes and its effect upon our private lives, came also the development of more public uses of electricity, such as, the telephone, the radio, and the movies. The spoken word became more significant as its ability to be heard by more and more people at once increased. The spoken word, with its greater flexibility, due to intonation, emphasis and overtones, can more easily arouse people emotionally than the printed word. Appeal to reason yields to appeal to emotion. Whereas, previously, a speaker could sway an audience of at most several thousands at any one time, it is now possible to reach millions and arouse them within minutes. Whereas, previously, events which occurred in distant parts took some time to reach the attention of the people, now almost every point in the world can be heard from within minutes or at most hours. The impact of an event which has just occurred is far greater than if there is a significant delay in hearing about it. The further removed an event in time, the less emotionally potent it is. The world has grown smaller and smaller, closer and closer together.

Vision, always a significant source of emotional gratification in man, now responds en masse to the Hollywood version of life and amusement. Now, through the medium of the movies, large parts of our population are subjected to the same rather standardized emotional situations, almost simultaneously. Entertainment, which before the introduction of mass production methods (about which I shall have more to say later) frequently required the more or less active participation of the individual, is now to a much greater extent, passively experienced.

Let us turn now to a consideration of the gasoline engine, particularly in its mobile form, the automobile, which has wrought equally far reaching changes in our society. First, let us consider its effect upon the physiognomy of our country. In the past thirty years, the external appearance of our countryside has been profoundly altered by the automobile. Twisting, winding, dirt roads which followed the contour of the landscape, have been replaced by broad, straight bands of cement and asphalt which cut through natural obstacles with studied nonchalance. Towns and cities which were once days of travel apart are now separated by only an hour's ride. One can now drop in quite casually to visit people whom one formerly saw only on special festive or solemn occasions. And our cities have been even more deeply affected. One has only to contrast the congestion and

centralization of our older eastern cities, or of, let us say, San Francisco here in the West, with the appearance of Los Angeles, to realize what a profound change has been wrought in our lives. Los Angeles has spread and sprawled over an enormous territory in the last decade, primarily because of the development of the automobile. Only recently it was estimated that over eighty-five per cent of the city's population was dependent upon personal automobiles as a means of transportation. Living conditions influence psychological attitudes, and the automobile has most certainly changed our living conditions. The dichotomy of country and city has been greatly diminished in these recent years.

There are yet further, more indirect effects which have resulted from the practical applications of electricity and the gasoline engine. These are not peculiar to these two sources of energy, but have been greatly accelerated by them. I am referring to the increasing industrialization of our nation, so marked in our mass production industries. Characteristic of mass production is the replacement of a finished product, made by a single skilled individual, by the production of single parts of a highly standardized article. For the individual this means, psychologically, a loss of the feeling of identification with, or pride in the finished product which was so characteristic of the earlier craftsman. There is also a loss of the feeling of accomplishment, of mastery, of completing a task, as well as the lack of satisfaction in having a particular special, socially useful skill. Routine repetitive, unskilled, incomplete work characterizes mass production. This type of work creates great feelings of insecurity in the individual, particularly with regard to economic status. If no special skill is required for a job, the workman can be easily replaced. There is little psychological job security. Thus, while mass production has made us the leading nation in the world from the point of view of material advantages, it has done so at the price of increasing the feeling of insecurity in the individual and has deprived him of certain other important emotional gratifications. I am by no means becoming nostalgic for the so-called good old days. These appear to me to be anything but good in many respects. I wish simply to emphasize the fact that material changes in our culture must have definite psychological effects on the individuals who make up the culture. The emancipation and liberty, the tremendous material gains we have made through electricity and the gasoline engine and their various applications (the list of which could be expanded far beyond the things already mentioned) have, however, most definitely affected the structure and function of the individual and the family in our society.

The family is the basic cultural unit of society. It is the family which transmits the culture of our society to our children. It is through the family that the child learns about the world. It is in the family that the child acquires its first profound attitudes toward the world. It is the family which conditions the character of the individual who later grows up to take his place in society. If the structure and function of the family in society changes, the effect of the family upon its children will change.

All the forces described above, the effects of which have been only briefly outlined, may be labelled centrifugal forces in relation to their influence on the closeness and cohesiveness of the family unit. Before the introduction of these factors, the home was much more the center of family life, much more of a centripetal force. Because of the earlier relative immobility of society, children tended to remain much more in the vicinity of the places in which they grew up. They were much more closely identified with the small local in-group, or with the section in which they lived than at the present time. Family life, both during the day and night, centered much more about the home. But with the development of the centrifugal forces described the parents also tend to center their activity much less around the home and family than ever before. In addition, children are exposed to much more powerful mass influences from a very early age onward. The whole pattern of values passed on to the child by the parent changes. The child's relation to and reaction to the world changes as the parent's psychological reactions to environment stresses change.

It would be interesting to pause at this point for a moment and speculate about the effect of these social forces on the symptomatology of the neuroses and on the changes in the relative

frequency of the different type of neuroses, but I am afraid that this would take us too far afield. However, I cannot refrain from indulging in one speculative fancy. It has been said that hysteria occurs far less frequently at the present time than it did at the turn of the century, while on the other hand obsessive-compulsive neuroses, character disturbances and psychoses have apparently increased. I do not feel that these statements can be accepted without reservation, because other factors enter. However, we may perhaps say this much: personal security in relation to the family and its stability, as well as social security in relation to one's place in society, were greater in that period than they are at present. On the other hand, sexual taboos and moral attitudes in general were much more rigid, restrictive and repressing than at the present time. This change in emphasis is closely related to the influence of the centripetal effects of the forces we have been discussing. The psychological changes within the individual and the family unit may well have affected the clinical pictures presented by patients.

But wherein lies the importance of these considerations for psychiatry? Dynamic psychiatry places decisive emphasis on the role of the parents in forming the character of the infant and child. To take but one example of many, consider the effect of a broken home on the emotional development of the child. Dynamic psychiatry is and must be interested in the social forces which affect the family and the individual.

But what do we mean by the term 'dynamic psychiatry' which has been used so frequently in the course of this presentation? Let us see if we can sketch its outlines in broad terms. There is much that is controversial in modern dynamic psychology and psychiatry, as there always is in every young and rapidly developing science. But there are certain fundamentals which are basic and can be accepted by all representatives of the dynamic approach, no matter how much they may differ with regard to other matters. I do not wish to enter into any controversy. I wish merely to present to you in a general way what I feel is basic and valid in our science.

The most basic concept of modern dynamic psychiatry is that of 'psychic determinism.' This is the principle that what we think, feel and do is determined by our past life and experiences. In the physical world determinism has long been an accepted scientific principle. We think in terms of cause and effect in relation to physical events. But in the psychological field this concept was introduced only relatively recently by Freud. Yet it is the cornerstone upon which all dynamic psychological science rests. We are the products of our past. Our reactions, our thoughts, our actions, our fantasies, our hopes and aspirations, our emotions, our relations to others are not random or accidental, but are determined by the patterns of our experiences from early childhood on. This may appear rather elementary to you, but it is only through the logical and consistent application of this principle that we can understand what actually goes on within us.

But we do not remember everything which has happened to us, we do not recall the incidents of our lives. We forget, we are not conscious of our thoughts, feelings and emotions in relation to many significant events and people. And this leads to a necessary corollary principle to that of psychic determinism, namely the concept of the dynamic unconscious. By the *unconscious* we mean all that which has been felt and experienced by the individual of which he is not aware, but that of which the individual cannot become aware except by some special means. This means that each individual undergoes many experiences which are so completely buried in his unconscious that he cannot bring them to the surface at will. This occurs particularly with regard to emotionally significant painful experiences, frequently in early childhood, and therefore necessarily in relation to the immediate family of the child, particularly the mother and father. It is here then that we can see the significance even more clearly of my earlier discussion with regard to the effect of certain environmental forces upon the family constellation in our society.

How, then, do we utilize these basic principles in relation to the treatment of psychiatric cases, psychotic, or neurotic individuals. Our therapy consists of the old Socratic saying 'know thyself,' expanded and enlarged to read: —Know not only thy conscious self, but thy unconscious self as well. We apply a general scientific principle to the intricacies and con-

fusions of psychosis and neurosis. The greater our knowledge of any particular thing in nature, the greater our ability to work with this material, to use it in a rational and scientific manner. We maintain, in applying this principle, that the more an individual knows about himself the more he understands his own emotional reactions to himself, to the people around him and to the world, the freer he is to act in a rational, reasonable manner.

The actual application of these basic principles therapeutically is a difficult and exacting task. When one considers the enormous complexity of human thoughts and feelings, it is easy to understand why therapy is of necessity so time consuming. But as yet we know of no other method which can hope to unravel these problems.

We must start from the point that no matter how bizarre an individual's behaviour, no matter how strange or unusual his thoughts or feelings, there is some meaning to them, of which the person himself is frequently unaware. The most fantastic reaction of a psychotic patient to an apparently innocuous occurrence cannot be simply dismissed as 'crazy.' It merely means that this reaction, so completely inappropriate to what occurred as to be incomprehensible to the normal person, has an unconscious significance for the patient. Even the word 'Salad' of a severe schizophrenic can be interpreted and understood as having meaning if the psychiatrist has the time and the patience to unravel it. Of practical significance to all of us, however, is the knowledge derived from this, that an unreasonable outburst of anger or temper on the part of a patient with whom we are working (or to extend it even further, on the part of a friend or relative) is not just a whim or fancy, but is based upon some unconscious association between the precipitating event and some previous emotional experience.

If one understands this fully, it follows that instead of responding in an emotional way to the unreasonable outburst, or simply tolerating it, we can utilize the incident in order to enable the patient to gain a little insight into his ways of reacting to situations. Let us take a little clinical example. A patient, shortly after beginning therapy, accused me of having discussed his case with two people whom he had never seen before but who had left my office while he was waiting for his appointment. He stated, "I know my evidence is flimsy. One of them looked at me peculiarly as he left. There is no use in your denying it, because I've made up my mind that you would deny it and that I won't believe you when you do." Instead of attempting to deny the accusation, which obviously would have been unsuccessful, or simply reassuring him that whatever he said was of a confidential nature, I asked him why he thought he felt that way. He replied: "That's what everybody does. They promise things and then do what suits them best. Nobody cares about anybody else's feelings." I said nothing and waited. After a long pause the patient said very bitterly, "That's just the way my father always acted. He'd promise me things but if it didn't suit his purpose he wouldn't keep his promises. He'd say anything to get me to do things but he never really meant it. I'd do what he wanted me to but he just did what suited him best." We can see in this example an illustration of many things. Reassurance would have had no effect whatsoever, in fact, would have produced the opposite of what was intended. The patient would have become more firmly convinced of the validity of his suspicions. By permitting him to express his thoughts and feelings he produced material related to a very fundamental attitude which permeated all his relationships with people. One of his main complaints on entering treatment was that he was too reserved with people, that he couldn't come out of his shell. During the course of the interview in which the above incident occurred he suddenly realized that he really actively distrusted everyone and was quite suspicious of them, and that this was definitely related to his feelings towards his father. There is much more we could talk about in this simple incident, but I am afraid it would take us too far afield.

What has been found as a result of the painstaking and detailed analysis of many individual cases is that emotional constellations of great significance and importance for the individual underlie the conscious thoughts, emotions and motives of neurotic and psychotic patients. Through other investigations it has been shown that the mental mechanisms and various types of psychological defenses which were found in neurotics and psychotics were

also present in normal people. For example, projection, that is, attributing to others impulses or motives which really lie within one's self, is most strikingly seen in paranoid schizophrenics. But we all project to a greater or lesser degree at one time or another. Rationalization is another common mechanism which we all use. It consists of finding seemingly rational logical reasons to justify emotional reactions or attitudes within ourselves. I think we all catch ourselves doing this from time to time, but most frequently we become aware of it in other people who wax "righteously indignant" about some particular thing. At such times we all feel that something in the situation does not ring true. Rationalization is epitomized in the famous quotation: "Methinks he doth protest too much." I could illustrate other universal mental mechanisms also, but I am afraid that time does not permit.

There is one other subject upon which I should like to touch briefly before going any further, namely the role of dreams in our life. Freud was able to demonstrate clearly and brilliantly that dreams, far from being meaningless and silly, had a definite unconscious significance. He proved beyond shadow of doubt that the purpose of the dream was to permit the expression, in the distorted form in which we become aware of it, of unconscious unfulfilled wishes and desires which we frequently could not admit to ourselves. The study of dreams and dream analysis is a particularly fascinating and important aspect of modern dynamic psychiatry, but unfortunately again it is a subject which would take us very far afield.

From these detailed studies have emerged certain definite concepts with regard to the dynamic structure of the personality. The conscious part of the personality is an easy concept for us to grasp, and is the part of ourselves which we accept most readily. The term "ego" as used in modern psychiatry includes this part of the personality, but has a broader meaning as well, because parts of the ego are unconscious. What is commonly called conscious is included in that part of the personality referred to as the "supergo," that is "above the ego," but again here the dynamic concept has a broader significance. The final part of the personality is technically called the "id." This includes all unconscious material, the drives, impulses, urges, feelings, impulses which motivate so much of our behavior, but of which we are completely unaware and cannot become aware without overcoming definite resistance. Fleeting thoughts which we find so repugnant that we thrust them aside as completely alien and foreign to our character are representatives of unconscious impulses. Illogical contradictory irrational feelings find their origin in this reservoir of the personality. The conscious ego cannot tolerate logical contradictions or the simultaneous presence of two opposing feelings, such as, for example, love and hate. It thrusts one or the other away, pushes it back into the unconscious. But this conscious ego is of the greatest importance to us therapeutically, because it is that part of the personality which is in contact with external reality, that part which establishes contact with other people. It is through the ego that we work therapeutically. We only become aware of the other structures through the medium of the ego. In therapy our ultimate purpose is to make the ego aware of what is present in other parts of the personality, thereby strengthening it in its ability to cope on the one hand with external reality and on the other with impulses coming from within, from the other aspects of the personality.

This, then, in brief is the dynamic concept of the structure of the personality as conceived of at the present time. May I warn you that this outline is highly schematized and simplified, and that in reality it is much more complex and involved than appears from the above. But I hope that it will give you some impression of what is meant by the term personality. Let me add one further warning statement. The structure of the personality, as outlined above, must not be conceived of as actual structural parts of the mind, but rather in terms of dynamic forces which are interrelated and which interact with one another.

Much of what I have said has been rather abstract and theoretical. I should like to present a brief summary of a case which may serve to illustrate some of the principles which I have been discussing. A young ex-Air Corps pilot appeared at our clinic for treatment following an outburst of physical violence during which he had for no apparent reason

suddenly attacked and beaten up a fellow employee. He complained of extreme irritability which resulted in numerous episodes of physical outbursts against other individuals in the year since his discharge from service. He felt under almost constant tension. He was restless and had difficulty in sleeping, being disturbed by nightmarish combat dreams. He felt anxious and apprehensive. He could not concentrate on study or on his work. He had been in the Army for over three years, had very successfully completed his pilot training and while overseas had flown on a number of dangerous combat missions before being shot down over enemy territory and taken prisoner. He escaped from the prisoner-of-war camp and joined the partisans of the occupied country in which he had been interned. While fighting with the partisans he had killed a number of Nazis as well as some of the natives of the country who were hostile to partisans. He was finally liberated when our forces entered the occupied country. He suffered from no difficulties during all this period. In fact he felt that the whole Army experience, even including the prisoner-or-war period, was the best time of his life. He could not understand why his symptoms had suddenly begun upon his return to this country, and had been increasing in intensity and severity as time passed.

He was seen in the clinic over a period of seven months, with short interruptions from time to time when he failed to appear for his appointments for a week or two. During this time the following picture emerged. Little was learned about his earliest childhood beyond the fact that he had been a severe feeding problem as an infant. He had continued to be a very particular and choosey eater until after entering service. In the Army he had gradually overcome aversion to various foods, and after his prisoner-of-war and partisan experience had become a gluttonous eater. His parents had divorced when he was about six years of age. He condemned his father for the divorce, and felt that his mother was an angelic woman who had been badly mistreated. When the patient was about eight the mother remarried. The stepfather was an older man, silent, withdrawn and reserved, with whom the patient could never establish any type of warm relationship. He had never been able to establish any close relationship with a man, and had always felt freer and more at ease with women. He married a childhood sweetheart shortly after entering service, and until his return to this country had actually spent very little time with her. At the time he came for treatment he had separated from his wife because his symptoms had so upset his wife that she could not stand him any more.

During the first part of the treatment the patient spent most of the time talking of his war experiences, at first with a great deal of pleasure and pride, later with increasing anxiety. His combat dreams were extremely interesting. They always portrayed him in desperate situations from which he tried frantically to extricate himself, but without success. He would awaken just as his plane was crashing, just as the Nazis were taking him prisoner, just as his plans for escaping the prison were being discovered. Upon awakening he would be terrified, usually covered with cold sweat. As the contrast between his conscious attitudes towards his war experiences and his unconscious attitudes as revealed by his dreams and associations became more and more apparent to him, he became aware of the fact that he had actually felt great concern about his buddies who had been killed or shot down and that he felt extremely guilty about having killed non-Nazis while fighting with the partisans. This realization came at about the half-way point in therapy. In the second half of the treatment period he gradually began to see the relation between his present reactions and his pre-Army life. He was able to recognize that his hostility and outbursts of physical violence were over-compensatory reactions to underlying feeling of dependence and what he called "femininity." He stated that he never really had a positive male figure in his life who taught him what it was to feel like a man, so that "I only had a moving picture version of what a man was supposed to be like." Crying, pity, tender and affectionate feelings, sympathy were, he recognized, all associated in his mind with womanliness. Men were brave, fearless, courageous, daring, etc., etc. Thus, for example, whenever his wife asked him to help around the house, which he really liked to do, he would always respond with an irritable outburst because that wasn't part of a "man's job."

Following the gradual realization that one could still be a man and have doubts about some things, have sympathy for others, feel pity and shame, among other things, his symptoms gradually subsided. He went back to live with his wife and reported with pleasure and a note of astonishment in his voice that he felt much more grown up in the relationship now, and that he was able to help around the house and actually enjoy it. He regained his ability to study and concentrate and began to return to college and pursue a scientific career which had always been his aim before entering service. He was now able to hold a steady job, and did not blow his top at the slightest provocation. His combat dreams disappeared. His only remaining symptom was inability to control his temper when he got hungry. This he related to his prisoner-of-war and partisan experiences when he had frequently been hungry for long periods of time. However, I am sure that this reaction is also related to the fact that he was a feeding problem as a child. To have worked this out completely would have required much deeper and more intensive therapy over a longer period of time than we do at our clinic. Treatment was interrupted at this point by mutual consent since the patient felt he was getting along very well and felt fine.

It is interesting that eight months later the patient returned for a follow-up in response to a letter from me and reported that he was getting along very well. He had not yet entered college due to some technical difficulties in relation to the Veterans' Administration, but hoped that these would be straightened out before the beginning of the next semester. He still complained that he had to watch himself and see that he did not let himself get hungry because he would blow his top at such times. He had solved this problem by always carrying a bar of candy in his pocket for use at such moments. There had been a recurrence of combat dreams in the past few weeks due, he felt, to the newspaper propaganda about the possibility of another war and some activity at the plant at which he worked which had started rumors among the employees that the plant was engaged in war work again. This had increased his feelings of uneasiness. Upon examination however, it was revealed that his present combat dreams were of an entirely different character than before. They were no longer terrifying, but rather somewhat depressing. And, very significantly, in them he was not being overwhelmed or being caught, but was successfully coping with the situation. He stated, "What depresses me is that there is still so much hostility in the world and apparently still so much in me. But I feel that I can handle it much better."

What we see illustrated in this case quite clearly is the fact that the patient's symptoms, which disturbed his social and occupational adjustment so markedly, were definitely related to his past life, and to feelings and attitudes which were completely unconscious to him. Following the insight he gained through therapy he was able to deal with his feelings on a realistic adequate level.

I have attempted in the course of this presentation to touch upon some of the significant social factors which influence individual psychological attitudes, and to clarify the relationship of the psychiatrist to these social forces. It is my feeling that a psychiatrist must, of necessity, be fully aware of the social factors which influence the course and symptoms in the various neuroses and psychoses. But his particular province lies in the treatment of the individual. Due to the tremendous popularity of psychiatry at the present time, the psychiatrist is frequently called upon to express his opinion regarding various social events. We must remain ever aware of the fact that our science is essentially one of the individual, and that our methodology relates to and is derived from our experience with individuals. We are well equipped to examine and understand the impact or social forces upon the individual, but that does not mean that our methods are equally applicable to the social forces themselves. The science of society called sociology must include our findings with regard to the individuals in our society, but must also find other methods more fitted to examine and dissect the more complex interrelationships of social groups.

Adaptation of Media

PART II

By EDITH H. BROKAW, O.T.R.
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Two of the principal problems to be overcome in the use of equipment for bed patients are the stability with which it can be set up and the placement of the apparatus so that the patient can work comfortably. Both of these problems can be solved very nicely through the use of the Simmons all-metal equipment. The four corner posts of their Balkan frame can be attached to any hospital bed and the long side

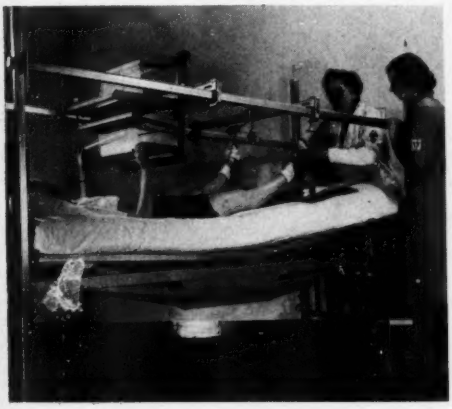

Illustration No. 8

bars can be adjusted to control the position and the height of the work above the patient and, to some extent, the angle at which it is held. The work itself is clamped or bolted to the short cross bar which can be entirely removed when not in use. If the corner posts are left on the bed, the long side bars can be raised to the top when the patient is not working to allow for nursing care. The total setup is pictured in Illustration No. 8 which shows the same versatile loom (mentioned in Part One of this article) set up for bed use. Illustration No. 9 is a close-up showing this loom used to give a bed patient exercise in hip abduction. Here an additional short cross bar is used on which are clamped hanging pulleys.

Illustration No. 9

The operational cords pass through these and are attached to bed roller skates. The rollers on these skates are castors which turn in any direction and the board on which they roll is slightly tilted up from the foot of the bed and is hinged in the middle to provide tilting to the side to take care of the arc of motion.

Cord knotting is a craft which offers much as a medium for exercise of the upper ex-

Illustration No. 10

Illustration No. 11

tremities. Because it is bi-lateral it is ideally suited to maintain the tonus of the muscles of the shoulder girdle which are used in crutch walking. In order to exercise these muscles for a patient who is lying flat in bed the frame holding the work must be directly above the patient. Picture No. 10 was taken with the camera pointing down from the ceiling. A wooden block like the one designed by Mr. Louis J. Haas[1] was riveted to one of the Simmons' clamps. This block is fitted with pipe phalanges on each of the three surfaces, horizontal, vertical, and diagonal.

The other half of the phalange is attached to a light board which enables work to be set up on at least four different planes. Illustration No. 10 shows the board with a cord knotting frame attached to it. This position is also excellent for a book rest for a prone patient. The making of shell jewelry is shown in Illustration No. 11 and here the position of the block is reversed.

Sometimes the equipment itself can be securely held to the crossbar by wooden clamps. Illustration No. 12 shows a typewriter set up this way. Again we are indebted to Mr. Haas[2] for the design of the wooden clamps which are bolted to the bar through the same holes which were used for the loom. Additional grip was had by lining the curved part of the clamp with leather.

The criticism has been made that it is not always possible or desirable to use a Balkan Frame. Since these pictures were taken one manufacturing concern[3] has brought out an extension swivel fracture bar which can be clamped to the head of the bed. Two of these can be used to support the short crossbar and should be very satisfactory for anything which only requires one crossbar.

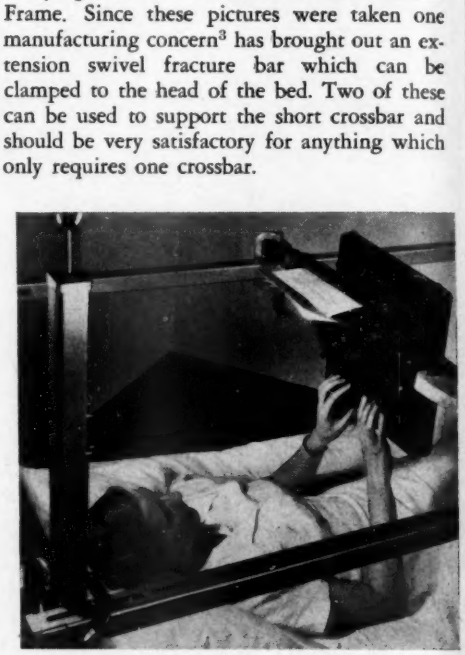

Illustration No. 12

In closing, the author would like to repeat the thought expressed in the opening paragraphs of the first of these articles, that these suggestions are not final or complete solutions, but only beginnings. It is sincerely hoped that the ideas presented will be considered just that, and that other therapists will develop them further.

[1] *Equipment Aids* by Louis J. Haas.

[2] Practical Occupational Therapy by Louis J. Haas, 1946 edition; chapter on bed equipment.

[3] The Simmons Company.

Photographs by courtesy of Presbyterian Hospital

Relation of Physical Therapy and Occupational Therapy In Problems of Flaccid Paralysis

By SUSANNE HIRT, R.P.T., *Assistant Professor of Applied Anatomy*
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Flaccid paralysis is a term used in contradistinction to spastic paralysis, indicating that the muscular dysfunction is of the hypotonic rather than hypertonic type. The dysfunction may be partial or complete and it may be temporary or permanent. It is a type of motor disorder which is the predominating sign of lower motor neuron lesions and peripheral nerve injuries. However, since it is a sign and not a disease, it may be present in combination with many clinical manifestations of disease or injury to the nervous system.

It is rather difficult to discuss techniques of functional therapy and evaluate their usefulness in a discussion of flaccid paralysis as a sign or symptom. The usefulness of any form of treatment depends to a large extent on the etiology, extent of damage done, accompanying symptoms and the time elapsed since onset of the disability. However, one can think of treatment directed at the muscular dysfunction as a kinesiological problem. This perhaps may be the most logical approach to as general a topic as this.

The main therapeutic goal in any flaccid paralysis case, whether paralysis is complete or partial, is to increase the functional capacity of the patient as a whole. The first step in the outlining of a program for functional therapy is a detailed analysis of the present status of functional capacity of individual muscles or small muscle groups. In the majority of cases a rather detailed muscle analysis can be made early without discomfort, pain or harm to the patient if the therapist has adequate training and experience in muscle testing. The generally adopted procedures of a muscle test are based on few and simple kinesiological principles. The muscle test is an evaluation of the patient's ability to actively contract individual muscles or small muscle groups. A muscle or group of muscles acting on an anatomical lever may be capable of one or more of the following:

1. It produces no joint motion of the lever, but at one and the same time shows visible and palpable contraction. Such a muscle is graded as demonstrating a *trace* of movement.

2. It produces joint motion only if the force of gravity has been eliminated; that is, moving the lever in a horizontal plane with elimination of friction. This is termed a *poor* muscle.

3. It lifts lever against the force of gravity without being able to carry any additional weight. This is called a *fair* muscle.

4. Finally, the muscle may be capable of overcoming manually applied resistance in addition to the weight of the lever. Depending on the amount of resistance given and the number of repetitions tolerated without undue fatigue, the muscle will be graded as *good* or *normal*.

Even though the principles of muscle testing are simple, the technique of applying these principles and the correct interpreting of observations require a great deal of experience, skill and, above all, a thorough knowledge of functional anatomy. All functional therapy, whether as part of physical therapy or of occupational therapy, depends for its final success largely on the therapist's ability to observe and interpret detailed muscle actions. In planning a therapeutic program neither a physical nor an occupational therapist should rely completely upon a muscle test performed by someone else. The present day muscle charts are far from being perfect. By and large they provide only a grossly quantitative picture of relative muscle strength. Many charts fail to record details of movement patterns observed by the tester during the process of examination. It is logical, then, that physical therapists and occupational therapists dealing with neuro-muscular disabilities should be well trained in the art of muscle testing.

In many respects there is a close relationship between approach to a good muscle analysis or test and the approach to the therapeutic procedure of muscle re-education or training. As a matter of fact, it is impossible to do good

muscle re-education without being able also to do a good muscle test and vice versa.

The main objectives of muscle re-education are first, to elicit voluntary contraction in extremely weak or temporarily paralyzed muscles; second, to regain normal or nearly normal patterns of motion among coordinating muscle groups; and third, to increase the strength, endurance and power of individual muscles.

Even though it has been discussed many times, it may not be out of place to re-emphasize the importance of the patient-therapist relationship. It is obvious that, if maximum functional capacity is to be achieved, the patient is expected to do his very best at all times. This can be accomplished only if the therapist is capable of gaining the patient's complete confidence and cooperation. Confidence can be won by the proper psychological approach. Maximum cooperation can be obtained only if the therapist is able to explain and teach the patient all necessary details of what he is to do, how he is to do it and why he is to do it. In order to be able to answer these questions a very clear picture must be kept in mind of what is to be achieved. In addition it is necessary to know of what the patient is capable. Frequent attempts to perform a desired movement resulting in failure may lead to frustration and discouragement.

The three main objectives of muscle re-education may be considered a basis of functional therapy and could, in reality, be held as a goal for the patient until he has achieved his maximum functional capacity. It is difficult to draw a definite line between various types of functional therapy. Actually they all work toward the same goal and one type of exercise can be carried over into the next phase of progressive re-training without any noticeable difference in the exercise except for the gradual increase in extent of contraction, endurance and speed developed in the individual muscle groups. It is difficult therefore, if not impossible, to say when muscle re-education should be discontinued and therapeutic exercises or functional rehabilitation replace it. A patient may benefit from all three types of functional therapy in his daily program which should include the functional activity program of the occupational therapist. If physical and occupational therapists are well acquainted with each other's methods of approach, possibilities and limitations, they can initiate a joint program at a much earlier stage than is usually the case. The indications for a functional activity program need not depend primarily on the augmentation in muscle strength; progress made in the patient's awareness of his neuro-muscular system, his ability to recognize coordinated and incoordinated movements and his response to verbal command may serve as a basis upon which to build an occupational therapy program. If the patient has reached this stage, functional occupational therapy should not have to wait until muscles are graded as fair or better in strength. Early occupational therapy may greatly expedite the rehabilitation of the patient.

An important factor to be considered in the building of a long term progressive program of functional therapy is the prognosis for increase in strength of individual muscles. If the residual paralysis is likely to be permanent, treatment must be directed toward the development of functioning muscle groups to superstates of fitness. If orthopedic surgery is a probable future consideration the surgeon will advise the therapist as to which muscles should be given special attention in order to make the planned surgery most successful. If there is partial paralysis with the probability of either some spontaneous return or hypertrophy of remaining functioning muscle fibers, treatment must continue to be directed towards re-education of those weak muscles or muscle groups and continued consideration must be given to the perfection of movement patterns. In the presence of totally paralyzed muscles overdevelopment of antagonistic muscles may be of value for future surgery. In most cases of partial paralysis such overdevelopment is likely to produce unbalanced and uneconomical movement patterns and, in many instances, may be a contributing factor of major importance in the pathogenesis of deformities.

The values, possibilities and limitations of careful muscle re-education in patients with flaccid paralysis have recently been discussed extensively by many workers in the field. However, the process continues of learning the scientific soundness of many procedures which, though empirical, appear to have a sound *a priori* basis.

It is possible to elicit contraction of isolated muscles by electrical stimulation of the motor area of the brain. This fact, however, does not permit to draw the conclusion that voluntary effort can produce contraction of isolated muscles. Recent electromyographic studies on normal muscles, a procedure which records the action current of contracting skeletal muscles, has helped to answer some questions and will doubtless be of continued help in the future. It was found that voluntary movements are made up of characteristic patterns of muscle action which vary only little in normal individuals. However, the number of muscles brought into play for any specific movement may vary greatly with the intensity of the contraction, the speed with which the movement is performed, the size of the arc through which the limb is carried and, finally, with varying positions of the limb as a whole. Electromyographic studies reveal that supination of the forearm, for example, can be done without the aid of the biceps brachii, if the movement is performed very slowly and without internal or external resistance. The biceps, however, was found to come into action during the last few degrees of the complete normal range of this movement. A similar observation can be made on the pronators of the forearm. These observations seem to indicate that it is possible to isolate muscles from their normal synergists, provided the movement is carried out with the least amount of energy possible. One might, therefore, draw the conclusion that one of the principles of normal movement patterns is economy of energy, which also is the prime characteristic of coordination of movements.

If it is possible to produce relatively isolated contraction of normal muscles by reducing the energy used for performing the movement, it seems likely that the same thing can be accomplished with weak muscles, provided they are given a chance to perform a purposeful movement. This end may be accomplished by placing the involved muscle or group of muscles into an optimum mechanical position in relation to the bony lever. Active contraction of weak muscles, that is, muscles grading less than fair, can be facilitated by allowing the movement to be carried out in a horizontal plane with as much elimination of friction as necessary. The physical therapist uses the horizontal plane in active assistive exercise. The occupational therapist may use the horizontal plane with the help of the sling suspension. A patient may be able to perform normal activities with muscles which grade less than fair if the arm is well supported in a canvas sling attached to an overhead spring. One can further facilitate contraction of weak muscles by increasing the angle of pull which exists between the long axis of the muscle and the long axis of the limb to be moved. Weak muscles frequently can carry a limb through a limited range of motion and yet be unable to initiate the movement. This is due to the inertia to be overcome and due to the relatively small angle of pull which exists in the resting position. The physical therapist frequently carries the limb passively through the first few degrees of the arc of motion in order to enable the patient to become aware of his ability to produce active movement of the limb. The occupational therapist can easily provide support for the limb in a position which eliminates, at least temporarily, the necessity of the patient initiating the movement from the normal resting position.

During the early period of muscle re-education the patient is not likely to complain of fatigue. One must, therefore, look for and be able to detect the outward manifestations of this condition. The effects of fatigue on muscle itself appear not to be detrimental. If increase in strength and endurance are desired, a muscle must work at least to the point of fatigue. However, if the functional activity of a weak muscle is carried on beyond the point of fatigue, the patient may have changed his pattern of motion. The fatigued muscle or muscle group may be at complete or almost complete rest, while substituting muscles continue to carry out the movement in a somewhat similar pattern. Every observant occupational therapist is acquainted with this fact. However, unless she is in the habit of observing and palpating individual muscles during their action, the patient may frequently "cheat" without being detected. A few common examples of easy cheating are the use of the clavicular section of the pectoralis major for forward elevation of the upper arm while a weak anterior deltoid is at complete rest. The movements are similar but not identical. Another example is

the opposition of the thumb which can be imitated to some extent by various combinations of other thumb muscles. Fatigue, therefore, is detrimental mainly in the sense that it produces faulty movement patterns which if carried out long enough become habit and the patient must return to the initial stage of re-education.

Normal pattern of movement is understood to be harmonious action of various muscle groups, working together towards the same goal. Main movers alone can rarely produce normal motion. During normal movements a great number of synergists are brought into play reflexly. They may be called stabilizers, fixators, guiding muscles or just synergists. Ordinarily the individual is not aware of the action of these muscles and it must be admitted that it takes some practice to become aware of them. Studies in functional anatomy can reveal the action of these muscles and one can learn to watch their action in patients. This is important because they frequently are the clue to why a patient is unable to perform a certain movement although the muscle or muscles which according to the textbooks produce that movement may be graded good or even normal. For normal abduction of the humerus one needs more than a normal deltoid and supraspinatus. During the very beginning of the movement it is necessary to stabilize the shoulder girdle. One, therefore, watches for the action of the lower trapezius. During continued elevation it becomes necessary to hold the scapula firmly against the rib cage to allow it to abduct and rotate smothly. This action is performed by the serratus anterior. Finally, in order to carry the arm beyond the right angle it must be rotated laterally. If the lateral rotators of the humerus are weak, they may be entirely responsible for the patient's inability to carry the arm through the complete range of movement.

If the occupational therapist is aware of all these possibilities, she may easily adjust the patient's activity to an arc of motion which will permit him to perform a task without forcing him into faulty habits. She may even be able to adjust an activity in such a way as to allow the patient to use and strengthen the weak synergists before continuing with an activity which cannot be done to the patient's satisfaction or advantage.

Finally, it may be desirable to teach the patient substitutions if the prognosis indicates it. That means he will be taught to use muscles in a manner in which they are not used normally or at least to an extent which surpasses normal. Even substitutions which are abnormal movement patterns can be taught in such a way as to appear, if not normal, at least inconspicuous and acceptable from an esthetic point of view. A patient using the elevators of his pelvis for paralysed hip flexors during walking may seem to force the pelvis upward against the chest with every step he takes. Or, he may learn to do it gently and rhythmically so that a layman would hardly detect the presence of this functional substitution. The same may be true for any well learned substitution of the upper extremity.

Functional therapy is a field of unlimited possibilities for the curious and investigating mind. There is much yet to be learned. There is much which the physical and occupational therapist can contribute. The closer they work together the sooner will the patient's need be met.

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Occupational Therapy in the Rehabilitation of the Poliomyelitis Patient

By Sue P. Hurt, O.T.R.

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Occupational Therapy is rooted in the following interrelated concepts that today have become axiomatic:

1. The patient is a person and must be treated as such.
2. Mind and body are interdependent and mutually affecting. Every disabling condition must be considered in relation to its psychosomatic and somatopsychological aspects.
3. Activity in the form of recreation, learning, productivity is basic to normal development and living.
4. Maintenance of as much of life's normal aspect as possible lessens regression, saves time in treatment, and assures a greater degree of recovery.
5. Every patient must participate actively in his own recovery, with benefit of opportunity and guidance.
6. Recovery means not only shaking off the dust of the hospital, but fitting again as a happy, productive member, into a community.

If these concepts are our reason for being, what have we to contribute to a program of recovery that accepts them as basic?

Our tools are activities—not to be symbolized by baskets and busywork — but the whole gamut of activities around which normal lives develop in our culture, activities which go to make up our round of recreation, education and the earning of our daily bread. For what cannot be brought in toto to the particular patient environment, can be brought through the medium of the printed page, sound or picture. There is no interest for any age group that it is not possible to satisfy in part. For our tools work with mind and muscle, and what is not physically feasible can be the subject of keen interest to be learned about and appreciated.

Since the occupational therapist works with both mind and muscle, she can begin as soon as it would be of help to the patient to have something to think about, something to allay anxiety and apprehension. Dorothy Richardson, O.T.R., describes her work with poliomyelitis patients at Indiana University Medical Center thus: "In almost all cases the resident physician signs a prescription for occupational therapy as soon as the patient is transferred from the isolation ward (three weeks period as prescribed by law). Many patients are still in the acute stage. Maintenance of rest position is paramount. Much may be done to help the patient adjust to hospitalization and needed treatment and to allay apprehension. The therapist plans a program for mental activity, or for passive participation. In daily bedside visits, usually brief, the therapist establishes confidence, with each visit brings something pleasant, interesting, that would appeal to the individual patient. Perhaps a new tune on a Thorens music box, a hand puppet, a nature interest or hobby line, depending upon the age and background of the patient. Through this period a portable musical instrument, usually a record player, is used to give programs three times a week at the entrance of each ward. Music to be used is selected very thoughtfully; pleasing in melody and harmony, smooth in rhythm, and within a limited dynamic range. The program usually starts with a number that will be generally familiar, including something easily understood, something new, lightly impressionistic, ending with music soothing and quieting in character."

Caroline Thompson, O.T.R., Assistant Professor of Physical Medicine, University of Wisconsin Medical School, writes of the use of occupational therapy in the acute stage to divert a child who is apprehensive about the post-respirator period. She writes too that an "adult in a respirator may want to read. It would be the responsibility of the occupational therapist to provide either projected books or a reading apparatus so that the patient himself might turn the pages by a suction tube."

This working with mind never ceases to be important throughout the whole program. Dr.

Nathaniel Warner of the Payne Whitney Psychiatric Clinic, writing of his use of occupational therapy with troops awaiting combat,[10] suggests that it fills a like need with the hospitalized civilian patient. Both soldier and patient must "adapt to a mode of life foreign to their previous experience" and both face an uncertain future. Under the head "Occupational Therapy and Morale" he writes: "Perhaps the most obvious way to enable men to face the discomforts and dangers of military life is to build up and maintain their morale—it is also well known that the speed of recovery of patients in any hospital is closely related to their morale." Morale he defines as "the net satisfaction derived from acceptable progress toward goals or from the attaining of goals" and suggests that their attainment gives satisfaction and the desire to tackle new goals. He writes: "By helping the patient to find satisfaction in the pursuit of various secondary goals, the occupational therapist acts as a morale officer on the wards. In this way she may enable the handicapped individual to achieve a more wholesome and contented attitude toward his total situation. Such an improved attitude can readily spell the difference between continuing disability and satisfactory adjustment to life." Under "Occupational Therapy and Emotional Conditioning" he has this to say: "There is good reason to believe that the process of emotional preparation for a menacing future is not conducted entirely at the conscious level, and that even when the individual is not consciously aware of it, he is nevertheless undergoing mental activity aimed at the adjustment to his anticipated future. It may well be that by far the most important part of the adjustment process is conducted unconsciously. — The efficiency with which unconscious thought of a fear-producing situation is conducted will depend upon the extent to which various stimuli compete for the attention of the individual. The man who finds nothing in his immediate environment to catch his attention is very likely to become consciously preoccupied with his anxieties. At the other extreme, during the period a man's attention is fully occupied by his immediate environment as by an exciting movie or novel, he is unlikely to concern himself, consciously or otherwise with his anxieties. Somewhere between the two extremes unconscious activity should find its most effective expression. The optimum point cannot be clearly defined. Yet logic, as well as experience suggest that occupational therapy may distract and interest the individual enough to prevent conscious preoccupation, but at the same time, not confine mental activity so much as to impair its continuance below the level of conscious awareness." He summarizes the above thoughts by saying: "By gauging her activities toward the satisfaction of drives and therefore toward the elevation of morale, by reducing the tendency to conscious preoccupation, and by assisting in the unconscious assimilation of anxiety-laden situations the occupational therapist can play a role of great importance in the recovery of the patient."

The ill person's world shrinks. It is for the occupational therapist to help prevent this shrinkage. It has been said that the greatest problem facing any handicapped individual lies in the fact that certain kinds of activity and social behaviour are closed to him, the handicap serving as a never ending source of limitation and frustration. The occupational therapist helps to reorient interests in activities compatible with prognosis. She helps the patient accept the fact that he "must carve his life out of the wood he has." Someone has written: "We do not think that the normal human being is the one whose motor and mental abilities function effectively, but he is the one whose psychological activities run in a harmonious way; he conquers life anew each day. This is possible for the handicapped in his own way,"*

Because poliomyelitis so frequently selects the child or adolescent, it is doubly important that an environment be provided in which he can develop normally and without psychological trauma. Someone has said: "It is as lopsided for a hospital to give physical care and pay no attention to the other aspects of a child's needs as if we fed him one day and neglected him the next."[3] A psychiatrist writes: "With the disabled child the difficulty of engaging in

*Meng, H. Zur Socialpsychologie der Körperbeschädigten: as quoted in (1) pp. 85-87.

normal play activities is a serious obstacle to normal development. Because of this one frequently finds young handicapped children who are already little adults. (It is important) to avoid premature superficial development by providing opportunities for play."* Much more could be said of the need for normal activities for a wholesome psychological environment not only to prevent regression, but to stimulate growth which must take place for acceptance of self in spite of physical handicap, and for courage to live a full life.

But something must be said of the physical aspect of treatment and of occupational therapy's potential contribution toward physical restoration. First, as has already been cited in a quotation from Dorothy Richardson, Indiana University Medical Center, during the period of physical dependency when rest position is paramount, occupational therapy can aid in promoting physical rest through mental rest. Miss Richardson continues: "With cases in which there is no involvement of the upper extremities, or in which spontaneous recovery has taken place, an activity program is indicated on the prescription by the physician, which will maintain normal tone and development of upper extremities. The activity chosen is light in material, one that may be accomplished well within the limited range of motion, keeping shoulders at rest, body in supine position and requiring the minimum of apparatus because of hot pack procedures." So much for occupational therapy as promotion of rest and as prevention of atrophy in nonaffected parts. What has it to offer as specifically applied exercise for affected parts? For this it must wait, not only until active motion can be initiated, but until patterns of coordination have been reestablished through work with the physical therapist. At this point carefully controlled activities offer opportunity for repeated use of the part serving to reinforce harmonious patterns and to increase strength. A careful creative analysis of activities offers possibilities for gradation of treatment as follows: for coordination—breakdowns from simple to complex, increasing the number of muscle groups involved; for strength—increase of resistance as controlled by position in relation to gravity and by the weight of equipment and materials; for endurance—light activity with high repetition. There can also be gradation of the arc of motion which is a factor both in coordination and in muscle development. Gradation of the position of the patient while performing activities gives functional treatment to muscles of balance and posture. The activity may be performed from a position of complete relaxation, a reclining semi-supported position, an upright seated position supported or unsupported, and from a standing position. All gradations as well as fatigue should be watched carefully in relation to substitution.

We hear a great deal today about functional evaluation and training, a progression from the more individualized muscle reeducation. Is not occupational therapy a logical medium for this progression as it applies to the upper extremity, offering opportunity for continuing development of control and strength, for evaluation of functional achievement and for development of specific control needed in daily activities. In the past several years this procedure has become recognized as a basis for occupational therapy in the treatment of cerebral palsy. Skills are used with an eye to the development of control needed for self-help. Elizabeth Martin, OTR, writing in the October, 1940, issue of *Occupational Therapy and Rehabilitation*, describes this approach to feeding training for the cerebral palsy patient. "If the child's grasp is extremely poor, we may have him start with finger painting for controlled shoulder motion. This craft can be used for specific shoulder motion and needs no grasp at all. If he has fair ability to hold something in his hand, we are apt to have him do very coarse assisted weaving for this same purpose. — The child reaches for the yarn and pulls it in the direction of his mouth and then returns it to the original neutral position and complete relaxation. If we gave him anything more complicated than this, altho he might be able to do it, he would not be able to concentrate on the shoulder control we are working for. — As the child's ability improves we can advance him to finer weaving. — When we feel that a child is ready to work with food, we may start him

*Meng, H. Zur Socialpsychologie der Körperbeschädigten: as quoted in (1) pp. 85-87.

in different ways, depending on his disability." This is functional training made enjoyable and leads directly to the practical problems of self-care. For the patient with a severe residual upper extremity handicap, occupational therapy has frequently devised mechanical aids for self-help.

So much for the upper extremity. What has occupational therapy to offer toward ambulation? In preparation it offers graded activity for crutch walking muscles of the upper extremity and shoulder girdle for increase of strength and/or endurance, which may be carried to the point of heavy resistance. In actual ambulation, occupational therapy offers a carryover of the balance and locomotion learned in physical therapy by providing opportunity for their rehearsal in standing and walking activities in games or handicrafts.

There are several other ways in which occupational therapy may aid in the program of physical treatment: as a control of activity between physical therapy treatments so that the benefit of the careful muscle reeducation will not be counteracted; as motivation for a prolonged program of exercise; and as a means of building general physical tolerance and of evaluating tolerance level.

It need hardly be said that clear, accurate and graphic records understandable to all who treat the patient must be kept for occupational therapy as well as for physical therapy.

We have spoken of occupational therapy's contribution to both the psychological and the physical aspects of treatment. There is yet a third phase of rehabilitation toward which occupational therapy has much to offer—that of helping the patient set realistic goals for his future vocational adjustment. Since many of the skills possible in occupational therapy have a carryover or direct lead to commercially remunerative occupations, with the aid of a trained vocational counselor, we can offer the patient orientation in vocational possibilities compatible with his own abilities and interests, we can observe his interests and aptitudes, and we can aid in estimating his physical handicap in relation to the physical requirements of the job. Jewelry has a direct carryover into watch repair, jewelry repair or engraving. Silk screening is a remunerative branch of commercial art. Leather work offers opportunity for toolers, lacers or for workers in saddlery. Bookbinding, printing, woodworking, pottery, drafting, clothing construction, photography, typing—all have direct prevocational value, and all are activities which can be made available to the patient through occupational therapy. It is obvious that "employment is one of the crucial aspects of the adjustment problems of the physically disabled."[1]

For the patient about to be discharged, occupational therapy shares with the other services in attempting to orient those responsible in the home. For the homebound patient, occupational therapy may be made available as long as a need is indicated. For the ambulatory outpatient, it offers a continually progressive program in a curative workshop or rehabilitation center, to bridge the gap between hospital and job training or employment.

In summary, occupational therapy attempts to bring the normal world of activity to the patient and to help him to use it in achieving an independent happy life. Occupational therapy is only one of the services which today make up the rehabilitation armamentarium. It is essential that the occupational therapist have deep human understanding, that she be specifically trained for the field of poliomyelitis, and that she understand the integration of her work with that of other services.

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ACKNOWLEDGMENT

Realizing that a summary of occupational therapy's potential contribution to the rehabilitation program of the poliomyelitis patient should be the combined thinking of qualified therapists both in the field and in education, a number of therapists were contacted for help. Those who responded and to whom I wish to express appreciation are as follows:

Miss Ada Ford, OTR., Instructor in Skills, Washington University School of Medicine, Department of Occupational Therapy.

Miss Frances Helmig, OTR, Director, Rochester Rehabilitation Center, Inc., Rochester, New York.

Miss Henrietta McNary, OTR, Professor and Director of Occupational Therapy, Milwaukee-Downer College, Milwaukee, Wisconsin.

Miss Eva Otto, OTR, Instructor and Assistant, Ohio State University.

Miss Dorothy Richardson, OTR, Indiana University Medical Center.

Miss Charlotte Steitz, OTR, Georgia Warm Springs Foundation.

Miss Viola W. Svensson, OTR, Acting Director, Occupational Therapy Department. Reconstruction Home, West Haverstraw, New York.

Miss Caroline Thompson, OTR, Assistant Professor of Physical Medicine and Director of Occupational Therapy, University of Wisconsin.

Mrs. Hannah Rile Weiman, OTR, Director of Occupational Therapy in Polio Division, Knickerbocker Hospital, New York City.

Miss Elizabeth Withers, OTR, Director, Cerebral Palsy Clinic, Memphis, Tennessee.

Postural Stress and Strain in Occupational Therapy

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Deviation from normal position of body segments or parts produces faulty posture, which in turn provokes stress and strain on skeletal structures — notably muscles, fascia, ligaments and bones. Strain may vary from simple muscular and ligamentous tension by stretching, all the way to pathological reactions which produce myositic, neuritic, periositic or arthritic results.

Because of this prevalence of deviation of body parts, it is of value to call certain facts to the attention of occupational therapists who handle patients with poliomyelitic or other types of motor imbalance.

Directors of physical education and physical therapy practitioners have long known that as high as seventy-five per cent of people—young and old—have postural faults, with deviations in the regions of head, neck, shoulder and pelvic girdles, and legs and feet. These deviations vary from simple pronated ankles, slight knock-knee or bowleg (with or without tilt of the pelvis) to actual flattening of arches, thigh rotations, and pelvic twists and tilts with secondary scoliosis. In so-called normal persons, deviations range from moderate fatigue slump with droop shoulders and forward head, to severe kypho-lordosis (round hollow back) with flat chest, relaxed abdominal musculature and severe round shoulders.

Obviously, members of the "polio" population had similar postural faults in like proportion before they were stricken, and the problems of "polio" are superimposed upon the previous faulty posture. For example, faulty relationship between opponent muscles in a deviated segment such as round shoulders, will mean that pectorals will be short and tight as against weakened and overstretched rhomboids. This condition perhaps will be accompanied by forward head, cervical lordosis, and perhaps increase of the dorsal spinal curve.

Now poliomyelitis, which is pre-eminently a disease which upsets muscle balance, is especially prone to involve the antigravity muscles—notably the extensors. The involved segments, being unable to oppose gravital stress properly, shift into bad positions.

If doctors and physical therapists are so interested in the muscular imbalance from the poliomyelitis that they forget the possible existence of postural imbalance, they see but one part of the picture. Two sets of muscles must be taken into consideration: (1) the weak, stretched muscles; (2) the strong short muscles. The natural effort will be exercise to build up the performance of the weaker muscles. But, while giving attention to the intrinsic action of the weak agonist muscles, it is equally important to appreciate the foundation from which they work. In other words, there must be appropriate control or stabilization of the base segment for the performing member to act with properly co-ordinated strength and skill.

Let us consider for a moment the shoulder girdle. When a person uses his hand in any movement of skill he cannot permit the shoulder to wobble or tip here and there; he must hold it still. When he fixes attention he must hold his head still in order to focus the eyes. In both instances he must use neck and shoulder girdle muscles to accomplish this fixation. All movements of skill which activate the hand and eye mechanism then, require a base stabilization in direct proportion to the force to be used and to the intensity of the concentration needed.

As we showed many years ago*, neck and shoulder girdle muscles are really auxiliary eye muscles. Incidentally, while writing this paper I am beginning to feel areas of tension and soreness through my trapezii. The continuous muscle action of writing is producing an anoxemia in the muscles which is being conveyed to my consciousness through the sensory mechanism in the form of a cramp-like sensation. This means that I have done enough for now and must relax and rest this mechanism.

Later: It is readily seen then, that a poliomyelitis patient, in bed or seated in a wheel chair, if given craft work that requires close concentration, can develop postural stress in shoulder girdle and neck. This strain is greatest during a patient's early efforts to overcome clumsiness and awkwardness. As the pattern of skilled movements becomes reflex the "know-how" develops and habit patterns are formed.

High degree of interest and enthusiasm also make for great intensity of effort which sometimes promotes inco-ordination and early fatigue. If uncorrected this may form a vicious circle.

The occupational therapist should remember that one of the earliest signs of fatigue is inco-ordination. Some patients, especially the hyperactive, lithe type who are prone to emotional instability, will become very tense, even hypertense; so, to avoid undue fatigue the period of application should be short. Patients of this type should be given gross rather than fine work. It should allow shifting of eye and head and hand (such as in weaving) and should not require handling of small tools or articles which limits the attention to a small, restricted area. Fine sewing, leather carving, jewelry making, etc., are to be avoided for such patients.

In connection with considerations of the active head and hand it must be remembered that the apparently inactive body is not really inactive. It is being maintained by the trunk muscles in a fixed position as a base of action. Consequently, the occupational therapist should realize that lack of attention to the patient's sitting position while she is teaching some apparently simple diversional activity may provoke or encourage an insidious deformity of spine and pelvis.

For instance, a child with one leg involved may have undeveloped buttock and thigh muscles and a pelvic tilt to the affected side. His effort of sitting up and holding the body against the push and pull of hand and arms effort, without sufficient counteraction, may overdevelop some trunk muscles. The result is progression toward trunk deformity.

Appreciation of structural and muscular imbalance is essential in the proper management of the occupational therapy aspects of treatment. Aside from the consideration of actual and potential skeletal imbalances the therapist should realize her important place in the

*Lowman, C. L., Relation of Ocular Manipulations to Spinal Alignment.

psycho-social aspects of the patient's problem of total rehabilitation. As a member of the reconstructive team she should check the patient's social service record in order to understand his home background. If there is no record she should find opportunity to become well acquainted with the patient.

Diversionary work may have been the prescription, but this should not be allowed to degenerate into a mere period of busyness. It should form an excellent opportunity for the occupational therapist to discover the patient's personal characteristics (likes, dislikes, evidences of mental depression, attitudes toward home, school, teachers, associates, etc., and his hobbies.) She should note any pertinent data for the record. Even though formal conferences regarding each patient's needs and progress are not held, informal interchange of such data should be made with other departments. When a new patient is assigned to the Occupational Therapy department, inquiry should be made from the floor supervisor or nurse as to special things that need attention. The department should be considered as a halfway station along the trail from physical reconstruction to social rehabilitation.

In planning for the patient's care in this department, about all that can be expected from most clinicians is a general prescription varying in accordance with his interest and approach to Occupational Therapy modalities. After the patient is seen and checked over in the department, the following points should be considered: (1) choice of activities; (2) frequency of treatment; (3) length of time of treatment (based upon fatigability); (4) intensity of effort, and participation in the activity selected.

As a teacher, the element of motivation will naturally be uppermost in the occupational therapist's mind. What should be her approach in accordance with the age level, the mentality, the type of individual (stout, lithe or medium)? For they differ, both mentally and physically.

The patient's response to the motivation should be noted, especially in those who are obviously problem cases. It may be a contest of wits in which success is ultimately gained by patience and understanding. The patient's ability to concentrate, and the length of his span of attention should also be watched critically. A short interest span may be a sign of fatigue or distractability.

It is important to have frequent breaks in the period for rest and release of concentration stress. A short period of stretching followed by relaxation should be given to everyone working in the department regardless of what work individuals are doing. This relaxation will relieve eyes, shoulders and arm muscles and allow for circulatory changes.

Patients sitting in wheel chairs can do a few push-ups from the chair arms to relieve leg and gluteal pressure on the brace rings, and give some use to big muscles of trunk. Simple hand, arm, neck and head calisthenics are also of benefit. As an added bit of therapy a few minutes of posture training in the sitting position is a useful part of the stretching procedure. The "sit tall" command, with "chin back," "neck firm," "spine straight," "tummy tight," "arms out and back," "shoulder blade pinch," etc., will benefit all. A patient who demands much personal attention will be helped by having to share in such a simple group procedure and will learn to realize that he too is one of a group.

Occupational therapists then, as well as physical therapists, should never forget that mind and muscle work together and that skeletal as well as mental stress is always to be considered.

Psychiatry in General Medicine

By NORMA SMITH, O.T.R.

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Paper delivered at the A.O.T.A. Convention November, 1947

Anyone employed in a general hospital will come in contact with patients that are sick in mind as well as body. We must understand that these patients are not merely imagining their pain, even if it can be controlled by a placebo; but that they are really suffering and may be aggravating their asthma, diabetes, ulcers or cardiac condition. We may understand that the patient has lost his appetite and has become malnourished because he is emotionally starved; but we must see him with his physical symptoms of starvation, dehydration, and lethargy, as well as his emotional symptoms. Or maybe we have a patient referred with an itching for which no physical cause can be found, and we understand he scratches himself instead of others; he is still an uncomfortable patient with an itch.

To be able to help these people we must know them. The doctor's referral should give us the diagnoses and tell us what he wants from us, but we need a great deal of information about the patient before we can carry out the doctor's order. We can learn a good deal by carefully reading the chart, the nurses' notes, social service report, progress notes and any other information that is at our disposal; but we need more than this, and to get it we must go to the patient. Purposeful conversation can be carried on with a patient and yet we can talk to him as a human being and not just a medical case. We should avoid direct questions, but rather let the patient talk, find out where he lived as a child, what he liked to play, what his family is like now (and *do* look at the pictures he shows you, as they often tell a great deal about his background), what he likes to do during a vacation, what he would like to do for a hobby, what are his hopes, his aspirations, his fears, and maybe his conflicts. Don't do psychotherapy; that is not our job; but learn to listen to what the patient tells and we may understand why he reacts as he does.

We cannot cure these patients, but we can help them — by filling in the gap between the doctor's visit and nursing care — so they can concentrate on a task instead of their conflicts. We can help the patient achieve success so that encouragement will be substituted for discouragement. As most people desire at some time to return to childhood, where there were no responsibilities and where they were well taken care of, the hospital, with this same type of care, can easily breed invalid habits. We may be able to counteract these by providing activity that will maintain the work habit. Aggressions can sometimes be worked out through self expression. If we follow through, we should be able to present an objective and intelligent observation through concrete evidence, so the doctor will see the patient from our point of view as well as from that of the nursing staff, laboratory or the administration.

If we are to accept the challenge of this type of patient, we need more formal training in the study of man, not only as an anatomical and physiological mechanism, but as a human being possessed of love, hate, desires, and fears that are capable of disturbing his soul and body. We need to put down in writing our methods, motives and conceptions; we need accurate and honest research. We should read the available material now published; and maybe we need to look ahead to some kind of graduate work. Our experiences, whether successes or flat failures, must be used to build and create our techniques. But most of all, we need to be emotionally mature, because today there are too many immature people that are compensating for their immaturity by dabbling in the lives of others and calling it "working with people." They may even do more damage to a person, who is already in conflict with his environment, by rejecting him as a patient, instead of trying to understand him. They are intolerant of his mental capacity, his physical symptoms, and his environment. Too often the therapist will excuse herself for this rejection by blaming

the doctor because he doesn't read her reports, or because he doesn't give her the necessary referrals. Or she may blame the hospital administration because it doesn't understand occupational therapy. But what does she do to overcome these excuses? She probably aggravates the situation by permitting jealousy, friction, and lack of cooperation to exist between her department and the rest of the hospital personnel. Or she may compensate by riding her occupational therapy students, or overcoming her feelings of insecurity by drawing up elaborate prescription blanks that a busy doctor is apt to ignore or creating new terminology to explain her techniques. She may even deny she is doing diversional occupational therapy or that it exists. She may become transient, moving from job to job, never satisfied and always seeking something that for her does not exist; or she may hide away in a dingy little shop for years and years, creating a pattern that makes occupational therapy dull, tiresome, and anything but treatment.

Our immature therapist cannot face the reality that her part in the treatment of the patient is a small one, and that she must proceed cautiously. Yet if she will write intelligent reports, will make hers the most cooperative department in the hospital, and humbly approach the patient because he needs her help, she will become a recognized part of the hospital and will be able to offer service that is of value.

Handedness Testing for Cerebral Palsied Children

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The occupational therapist treating cerebral palsied children almost immediately faces the problem of the child with undetermined handedness. In the majority of such cases it is necessary to give handedness tests before instigating further treatment.

The occupational therapist with her training in arm function and skills is usually called upon to do the testing in a cerebral palsy unit. It is, however, the responsibility of the doctor to make the final decision on which should be trained as the leading hand.

Specific treatment in the field of cerebral palsy has only become widespread in comparatively recent years, and handedness testing with these cases is still in a developmental stage. Since standard handedness tests are not applicable to a child with a motor handicap, each therapist has necessarily had to work out her own method of testing.

The following method of testing is one which has proved workable. This paper does not attempt to go into the question of dominance with the various aspects that enter into the problem in cerebral palsy cases, but simply to point out a few basic facts about the subject with which every therapist testing these cases should be familiar.

In the normal child most investigators agree that hand preference makes its appearance some time during the second half-year of life, and that the preference becomes more marked after 18 months or 2 years.[1] Therefore, handedness testing cannot be successfully carried out on a child under 2 years of age, and it can be made with more certainty after the age of 3 years.

If by three years of age some hand preference has not been shown, and the child still seems entirely ambidextrous, one or more of the following conditions are usually present: lack of speech or slow speech development, stuttering, emotional instability, fleeting concentration, mental retardation, or convulsions. It must be emphasized, however, that any one of these conditions should not necessarily be linked with the indeterminate handedness, but may be due to any one of many causes.

[1]Gesell, Arnold, M.D., The First Five Years of Life.

Material in this paper is in accordance with the theories of Winthrop M. Phelps, M.D., Baltimore, Maryland.

If handedness can be set, these conditions can be entirely overcome in some instances and mitigated in the majority of the remaining cases.

Where the above mentioned conditions are not present, but the handedness is still undetermined, as may be found true in some of the more severely handicapped cases, it is not advisable to force the issue but treat both arms and allow a choice in the different activities.

A large number of the indeterminate handedness cases are found among the mildly handicapped; the mild spastics, where the spasticity may be traced and therefore hidden, the ataxias, and the recovered ataxias.

In the spastic hemiplegias, where the damage is cortical, however mild the case, it is never advisable to treat the handicapped arm or train it as the leading one. Convulsions are likely to be initiated or increased, and the chances of mental retardation are greater. In the ataxias, where the damage is cerebellar, and the athetoids, where the damage is basilar, this problem is not present.

It proves advisable in general to train the least handicapped arm in the leading capacity, but this is by no means a set rule. From a practical point of view it is not often possible to make a satisfactory leading hand of the more severely handicapped one.

Both arms are treated and trained during the babyhood period unless there is a definite diagnosis of spastic hemiplegia.

Handedness cannot be set or shifted after a child reaches 14 years of age, and the chances of accomplishing either rapidly diminishes after 10 years of age.

In order to set handedness after it has been determined, it is usually necessary in the milder cases to confine the assisting arm under the clothes during the child's waking hours. When a child is just learning to walk and is unsteady on his feet, a mitt or bag of heavy cotton material may be used. This may be removed for ski or parallel bar walking practice. In the more severely handicapped cases, intensive training of the leading arm is usually sufficient. An arm is confined from six to a limit of eighteen months depending on the progress that is made with establishing the leading hand.

EYEDNESS. Considerable study has been done on eyedness and its importance in relationship to handedness. In the majority of cases the dominant eye is on the side corresponding with the dominant hand. In older children where full cooperation can be attained, eyedness should be tested and taken into consideration in the decision of the hand to be trained.

One simple test can be made by piercing a small hole in a sheet of paper, then holding the paper approximately six inches from the eyes, focus an object such as a light bulb (at room distance) through the hole with both eyes. With the paper in the same position, close first one eye and then the other and find the eye with which the bulb can still be seen. This will be the dominant eye.

Another method of testing is to put a patch first over one eye, then the other, while performing an activity which necessitates close eye and hand coordination such as typing. Very often a marked difference in speed and efficiency will be manifested.

* * *

The following test form is used. It has been filled in from an actual handedness test on a patient, as a sample, with explanations of the headings and means of deducting the information.

The testing is not dependent on the cooperation of the child. It can be carried out with observation and patience on the part of the therapist and with testing material chosen according to the child's mental and physical abilities.

It is preferable (but not always possible) to have the child seated at a table of correct height for testing the distal motions. The child should not be aware of the fact that he is being tested.

HANDEDNESS TEST

NAME: John Smith AGE: 3 yrs., 9 m. DATE:

DIAGNOSIS: Mild athetoid quadriplegia.

INHERITANCE: Mother's family entirely right handed. Father may have shifted as a child. Paternal grandmother left handed.

CONVULSIONS: None.
If one sided, which side?

HABITS which engage one hand, such as thumb sucking: None.

PREVIOUS TRAINING: None except self-feeding.
Self-feeding: Left hand, English manner of eating.
Coloring or writing: None.

HANDICAP: Slightly more handicap throughout entire right side.

UNDERLYING SKILL OR ABILITY: Possibly a little more skillful with left hand because of less handicap.

INITIAL MOTION: Approximately 65% right.

PREFERENCE: 58% left (summary of figures).

Summary of one month's daily testing by parent:

Activities necessitating fine coordination	Right	Left
Takes object	158	16
Completes motion	99	74
Ball throwing		
Throwing	128	38
Catching	103	64
General activities		
Hair combing, etc.	165	152
Coloring		
Takes crayon	130	42
Colors	39	122
Self-feeding	Left hand entirely (previous training)	

SUMMARY: This child is apparently a fundamentally right handed child, but since there is slightly more handicap in the right arm, the left hand has been used considerably more than normal, especially in activities necessitating fine coordination.

DOCTOR'S RECOMMENDATION: Train the right arm. Confine the left one under the clothes during waking hours.

* * *

The first six sections can be filled in from the medical record and from questioning the parent.

The same preference form, with activities listed according to the abilities of the child, is used in the daily testing.

CONVULSIONS

They often originate or are confined to one side of the body and should be noted. Training of this arm may increase the seizures.

PREVIOUS TRAINING

Parents may have influenced the choice of hands. especially in self-feeding and writing or previous treatment may have been concentrated on one arm.

HANDICAP

In practically all patients tested in a cerebral palsy clinic, there is, or has been, some motor involvement in the arms no matter how mild the degree, and this plays a large part in preference and in the final decision of the arm to be trained. This must be carefully noted in both proximal and distal motions by the therapist. Also copying, mirroring, tension, or overflow in the other arm should be noted.

Relative amount of handicap in the legs should be taken into consideration, since an entire side is likely to be more involved though the amount in the arm may be only trace.

The child who is unsteady on his feet may depend on the leading hand or on the least handicapped one for support, thus necessitating the use of the other hand while on his feet. This should be studied.

UNDERLYING SKILL OR ABILITY

In cases where the involvement is trace to mild, the underlying ability may be greater regardless of more motor involvement. This must be observed and noted.

INITIAL MOTION

A child may initiate a motion with one hand and complete it with the other.

PREFERENCE

For this part of the test the therapist should sit or stand directly in front of the child and pass or place the testing material in the center position. Both of the child's hands should be free to receive the object. Each activity should be carried out at least ten times, and the results carefully tabulated. (General observation in this part of the testing is unreliable.)

The preference testing should subsequently be carried out daily in the clinic by the therapist or at home by the parent for a period of approximately one month. The home testing by the parent should be made as simple as possible and with careful instructions given. Each day's testing *must be tabulated.*

Preference testing by the therapist at the first test should not be considered more than a clue. These children are prone to prefer one hand one day and the other the next. Only repeated testing can show a true trend.

TESTING MATERIALS must necessarily be varied according to the mental status and manual ability of the child. They should fall into four general groups: 1) involving proximal motions, 2) gross distal motions, 3) fine distal motions, and 4) commonplace activities. A few suggestions as to testing material are listed. The same materials may be used throughout the tests. (The greater variety, the better.)

1. Small ball—throwing, rolling, picking up.
   Dart throwing.
2. Large blocks—piling, placing.
   Large pegs—placing, removing.
   Small cone.

3. Small pegs.
   Mosaics
   Marble games
   Tiddly winks
   Crayoning—important—note separately.
   Writing
4. Eating—important—note separately.
   Opening door
   Turning on light
   Combing hair
   Pointing

The therapist should be able to make the entire initial test in most cases in one hour.

The daily preference testing for a month should take approximately ten to fifteen minutes a day.

Occupational Therapy and the Community Rheumatic Fever Program

By RUTH E. LYNCH, *Director, Heart Division*
Los Angeles County Tuberculosis and Health Association

Rheumatic fever and rheumatic heart disease among children and young adults constitute a major public health program throughout the country. Heart disease in adults is the cause of every third death today, and we know that too little has been done in the field of medical research and education to reduce the tremendous toll in human life and disability. Many people still consider heart disease the patient's "own business." The problems of rheumatic fever and rheumatic heart disease, which are only now becoming generally understood, challenge all of us to make the problem our business. The dramatic statistics provided by the Metropolitan Life Insurance Company showing rheumatic fever as the first cause of death, excluding accidents, in the age group ten to fourteen may seem unreal, although frightening enough. In many areas, rheumatic fever disables many, but kills few children in the school age groups. It is when we examine the data on deaths from heart disease in the young adult groups, that we realize the urgency of securing more and better care for children in the younger age groups where rheumatic fever begins its crippling career.

Applying the conservative estimates of physicians and public health workers that about 2% of our children of school age have rheumatic fever or rheumatic heart disease, we can estimate the minimum number of children in any community for whom medical care and all the necessary auxiliary services ought to be provided.

The experience of the armed services in World War II shows a high rejection rate for cardiac conditions, most of them rheumatic in origin and frequently suspected for the first time. Then the numbers of young men who developed rheumatic fever and were cared for in special hospitals throughout the country, had a double importance. Many families and communities heard about rheumatic fever, at least by that name, for the first time. Many physicians increased their knowledge and competence in dealing with rheumatic fever. And in the military hospitals, they also learned the nature and importance of supplementary service to medical care. Occupational therapy was even more unfamiliar to many of the doctors than the experience of treating large numbers of rheumatic fever patients. This combination of circumstances may well improve and expedite our civilian efforts in the control of rheumatic fever.

Rheumatic fever has been described as a chronic disease and although its specific cause is unknown and no miracle drug has been found for its cure, medical science has developed cri-

Summary of panel discussion, 1947 Convention of American Occupational Therapy Association.

teria for diagnosis and treatment which can be effective. Remembering that rheumatic fever is most often a chronic disease and that heart damage may increase with each recurrence of the acute phase, we can recognize and understand the danger of disaster for the patient's personality, family relationships, social and economic status. Thus, rheumatic fever and a program for its control is a community problem. Dr. T. Duckett Jones, whose long experience as medical director of the House for Good Samaritan in Boston qualifies him as the outstanding authority in the care of rheumatic children, says, "Rheumatic fever is primarily a problem of medical diagnosis and treatment. No physician, however, can provide for the rheumatic patient all the services essential to his recovery or well being. The physician must enlist and work with the nurse, social worker, home or bedside teacher and the occupational therapist."

The literature on rheumatic fever has only recently begun to include occupational therapy as one of the essential services for our patients. Since the plans for community programs are naturally in advance of their execution, it is likely that very few, if any, communities have even begun to provide occupational therapy for rheumatic children. It is important, first of all, for the welfare and progress of our rheumatic fever patients, and second, for occupational therapists as a professional group that the actual therapeutic value of this service be understood and accepted, not as a luxury item or "frill," but as an essential and component part of the patient's care.

As professionally trained occupational therapists, I see for you a double responsibility and opportunity in the developing of rheumatic fever programs throughout the country. First, and because your group represents a rather new profession, you can establish good public relations by your interest and affiliation in the overall planning bodies. This includes the American Council on Rheumatic Fever at the national level as well as the state and local programs in your various communities. If you have not already been invited to join with such groups, I urge you to discover where, in your own areas, such planning is under way or needed. Then take the initiative and offer your participation as individuals or as local professional units in the planning of rheumatic fever programs.

I have been greatly impressed with the public relations' possibilities, as well as those for real service to patients, in your professional contribution. You have a clearcut, well-defined service, capable of simple and dramatic interpretation to the medical profession, as well as to other professions, and to the general public. Yet, I am not suggesting that you as individually trained therapists divert your skills to those of organization and program planning. You need only to offer your cooperation and be ready to demonstrate your own skilled service. Your community should have either a local heart association or a rheumatic fever committee of a tuberculosis association which takes responsibility for coordination and planning of services. This group, often an integral part of a health council of all your public and private health agencies, or of a Council of Social Agencies, will accept your active help in planning.

Community organization has become a specialized field in itself and I hope your communities are providing this kind of professional guidance in program development. Just at the point where long range planning is started for a community, occupational therapy needs to be considered, not as a secondary or tertiary service, but as an essential complement to medical, nursing, social, and educational services. Too often, we see planning done without the benefit of professional occupational therapists, and rheumatic fever programs which interpret the need of the rheumatic child is recreational or diversional. In our own community, there is a new and enthusiastic acceptance of occupational therapy since the professional workers have established the serious and limited contribution they are prepared to offer. This is usually accepted first as seen in the inpatient wards and next in the convalescent units. Still largely unexplored, but certainly the greatest area for a fine service, is that in the home.

In Los Angeles we are just entering upon a demonstration project to provide occupational therapy in the homes of patients referred by our rheumatic fever and cardiac clinics. This will be a demonstration, not only of the professional service, but also of the possibilities for bringing occupational therapists into the community planning field.

Education for Occupational Therapy

Paper delivered by Miss Sue P. Hurt, O.T.R., Retiring Educational Field Secretary, at the 1947 Convention of the American Occupational Therapy Association.

Now for a brief but serious discussion of our developing profession in its many aspects, with trends in Education, which are specific efforts to keep up with it. We know that our medium of treatment is normal activities. We know that normal activities are the basis for human development and well-being physically, mentally, psychosocially, and economically. We know therefore, that O.T. logically touches every aspect of rehabilitation—the physical, the mental, the psychosocial and the vocational. Therefore, it is essential that the occupational therapist's training help her to be aware of this broad, many sided potential contribution and that it give her as much specific *knowledge* in each area as possible.

For the physical aspect of disability she must have basic knowledge and understanding in Anatomy and Physiology, Kinesiology, Disability Evaluation, Muscle Reeducation, Pathology, General Medicine and Surgery, Orthopedics, Neurology.

For an understanding of the psychological aspects of disability she must have courses in Psychology and Psychiatry. Especially important are Child and Abnormal Psychology. And it is essential that these courses be given with a dynamic approach in order that she may develop insight into psychological processes and the whys and wherefores of psychiatric problems, and the interrelation of the psychological and the physical aspects of abnormality.

She must have adequate preparation in a wide range of skills activities. Traditionally these have been handicrafts, which continue to be important. However, as the value of O.T. in pre-vocational orientation and observation and pre-industrial hardening and testing becomes established, greater emphasis is being placed on such courses as Printing, Photography, Shop Work and Radio. And Woodwork courses must now include not only the hand tools used in exercise treatment, but also power machinery. An equally important trend in O.T. for which our skills courses must prepare is the therapeutic use of recreational activities—games, sports, music, dramatics. These are beginning to be included in the O.T.'s training program.

Because the occupational therapist does not treat her patient in a vacuum, but in the total situation and in conjunction with other forces in the over-all rehabilitation program, we must give her an understanding of those other forces. Therefore courses in Disease and its Social Component, Social Work and Community Resources, Social Group Work, Vocational Counseling and Rehabilitation are important.

Of prime importance are the courses in O.T. Theory and Application. For as in any good receipt there must be not only the ingredients in proper proportions, but specific help in putting them together, so the O.T. must have not only knowledge of the physical and psychological aspects of disability, skills which are her treatment modalities, and an over-all picture of community resources, but she must have specific help in putting all of this knowledge together in a working program of O.T. She must have a clear understanding of the problems involved in rehabilitation specific to the various disability areas—the physically injured, the tuberculous, the mentally ill, the blind, exceptional children—of the over-all program to meet these problems, and of O.T.'s potential contribution to the whole. This is done partly in theory courses and emphasized more strongly in her clinical training which must include psychiatric hospitals, orthopedic hospitals or services, children's hospitals or services, general hospitals, and tuberculosis sanatoria.

We are facing today the same problem that doctors have faced—the problem of an expanding field and of a many-sided contribution, hence an expanding basic curriculum. We realize that, because we are treating both the disability and the individual behind the disability, and because all aspects of his total adjustment may be affected whether we find him in a mental, an orthopedic, a tuberculosis, or a general hospital, every occupational therapist must have the same basic training. But we are realizing that the *emphasis* varies with the disability field. And that for an O.T. working

with physical injuries it is essential that her grounding in Anatomy, Physiology, Kinesiology, Disability Evaluation and Muscle Reeducation be stronger than that which can be given in our present curriculum; that a further emphasis on Psychiatry is essential for those who remain in that field; that occupational therapy's developing place in the tuberculosis rehabilitation program brings with it a need for greater orientation in prevocational aspects. We have realized this need for further study for a long time, and we have had for the most part to do it on our own—take a course here and a course there, study, think, put two and two together. We are now beginning to demand opportunities for post-graduate study and for accredited courses leading to a graduate degree. Little of this has become an actuality as yet but it is decidedly in the wind.

Now for specific facts and figures. There are 25 schools of occupational therapy, 22 of which are accredited and three with accreditation pending. All but six of these schools have been started within the past six and a half years. There are three types of courses being offered:

The Diploma Course—prerequisite one year of college; length—three years including one year of clinical training; this is still being offered by eight schools.

The B.S. Degree Course — prerequisite high school graduation; length—from 4½ to 5 years including one year of clinical training; this is being offered by 24 of the schools.

The Advanced Standing Course—prerequisite a B.S. degree with certain prescribed subjects; length—a minimum of 18 months including clinical training; this is being offered by nine schools.

Clinical training is now being offered in Civilian, Veterans and Army hospitals.

And finally something on standards and professional development. The American Medical Association is the accrediting body for schools of occupational therapy. The standards which are the basis for accrediting were set in collaboration with the American Occupational Therapy Association. The accrediting is specific to the school. There is as yet no machinery for accrediting of the individual clinical training center. This is an essential part of our development and is not too far around the corner.

The American Occupational Therapy Association is our means for cooperative contribution toward professional development. Until recently this was approached entirely on the voluntary committee basis, the group concerned being the Education Committee with its two Subcommittees on Schools and Curriculum and on Clinical Training. Committee membership was made up from the directors of schools and clinical training centers. In recent years a grant from the Kellogg Foundation has enabled us to give impetus to the work of these committees through the establishment of an Education Office. It is essential for our professional development that we support this office in its undertakings.

Professional Attitudes

As Presented to a Group of Occupational Therapists of the Veteran's Administration

Attitudes are described as "feelings toward, which control action in relation to." Professional attitudes are attitudes toward a profession and they are attitudes which are basic to the highest in a profession.

We think of our profession, OCCUPATIONAL THERAPY, as a means of service—as THE means whereby we as individuals can contribute to the general well being most creatively, and hence most satisfyingly. We see it as fulfilling a vital need in any program that leads toward health. This is our attitude toward our profession.

What are the attitudes that we must have in order to be worthy of our profession? First of all, the attitude that we are part of a whole

with the focus of all effort on the patient—a service team with no thought of starring for O.T. or for ourselves. This means an understanding of the whole picture, with a sincere appreciation of the contribution of other professions which are a part of it, an understanding of the relation of our skills to theirs, a clear interpretation to others of our function within the whole, never forgetting the eloquence of a job well done. It means within our own department a team spirit, each one working with esprit de corps for the patient and for the whole. It means a healthy respect for authority and obedience to rules and regulations which are necessary for the good of the whole. (Discipline has been defined as the difference between an army and a mob.) It means respect for the property of the whole, which leads us to care for equipment and to conserve supplies. It means loyalty to the whole which carries over to the patient and gives him confidence in those responsible for his care. All of these are based on our attitude toward the whole as a service team with focus on the patient.

An inseparable part of the above is an attitude of analysis, of constant evaluation—viewing the broad aspects and looking at the big while not forgetting the little, thinking ahead yet ever mindful of the daily routine, an attitude of scientific research with no loss of human understanding and sympathy.

What should our attitudes be towards others —attitudes which are basic to wholesome personal relationships with co-workers and with patients? A professional attitude means respect for others and interest in their welfare. It means being able to feel as they are feeling while maintaining our objectivity in what to do about it. It means interest in the affairs of others without prying; respect for the sacredness of personal affairs; reticence in regard to our own; truthfulness, yet good judgment at all times in its use; criticism only where it will be of help; consideration for others in small things as well as large (our perfume and our smoke may not be pleasurable to them as they are to us). It means infinite tact such as can "pull a stinger from a bee without getting stung" or can refuse graciously money or gifts without hurt to the spirit which prompted it. It means having many interests which may prove contagious to others, and a readiness to "catch" others interests. It means dignity and friendliness without familiarity; freedom from emotional entanglement involving work relationships; fairness, prejudice neither for nor against; sincere appreciation of others efforts.

And what of ourselves more specifically, as cogs in the whole machinery? For ourselves it means individual integrity, responsibility, dependability; moral courage and self-reliance; self-analysis in relation to work; independent thinking yet openmindedness; eagerness to learn, yet confidence in using what we know. It means a seriousness of purpose in our work combined with enjoyment in the doing; maturity, yet understanding of immaturity. It means attitudes toward health in mind and body; balance of work and relaxation; poise of soul that reflects itself in our expression, our voice, our carriage, our habits of speech, our self-control.

There are many DO's and DON'T's which we attempt to instill into our students under the heading of ethics and etiquette:

Always be punctual.
Stand when superiors come into the room.
Address your co-worker as Miss or Mrs.
Don't sit on the patient's bed.
Don't smoke while on duty.
Don't discuss the patient's illness with him.
Don't go from one bed patient to another without washing the hands.
Don't mail a letter for a psychiatric patient.

These and many more have become the accepted manners and morals of our professional world, not arbitrarily, but because they spring from professional attitudes, attitudes toward our profession or attitudes which are basic to the highest in our profession—attitudes toward the medical team of which we are a part, toward our co-workers, toward the patient (our reason for being), toward ourselves in relation to it all.

Much of what we term "professional attitudes" are merely attitudes which are basic to gracious and decent living. The more such attitudes can become a part of us and of the students whom we are attempting to condition, the less we shall have to rehearse to ourselves or to them our DO's and DON'T's.

EDITORIAL

EXTENDING OUR SERVICE

Long before now you have heard us expound the fact that it takes all parts to make a whole. To those who would have a part or would play a larger role in the advancement of the profession, we point out that the *Journal* can be your medium. There is an opportunity for reciprocal service between the *Journal* and its readers.

Do all the members of your institutional staff recognize the principles of treatment which, for example, lie behind the rug your patient is weaving? Is their always time to explain that the chosen project is only the *incentive* part of a well planned and graded program of treatment? The project is the portion of occupational therapy which, like the upper section of an iceberg, is visible. Now it is commonly recognized that only one-eighth of an iceberg shows above the water line, but it is not so evident to all our co-workers that the project is only the medium by which a treatment is administered and that by far the greater part of occupational therapy—the core of it—bulks below the surface, discernible only to those who observe it over a period of time.

Our authors are writing to advance occupational therapy. We think they detail thoroughly the gist of the above paragraph. If you think it is not your forte to supply the *Journal* with articles or items, can you supply us with a larger circulation so the *Journal* will be able to speak for your profession in those places where your individual voice cannot reach?

The larger our reading public, the better medium we are for our authors, and the greater service we can render the profession. Without an increased circulation we cannot grow in stature and in utility.

It will help tremendously if your institutional library subscribes to the *Journal*—if not this year, then next. On one of your trips through the hospital, can you let your librarian or superintendent know you would like to have the *Journal* available with other representative periodicals on the current reading table? After all, occupational therapy is newer and needs more interpretation than do some of the other vocations.

We have heard that even patients have enjoyed reading parts of the *Journal,* and we have had letters to let us know that many doctors and nurses (not excepting those who have O.T. departments right under their very noses!) have come to understand occupational therapy through reading as they had not been able to do through simple observation. If this is true, and it is also borne in mind that staff cooperation has a prominent value, it would not seem an excessive expenditure for public relations to include a gift subscription for the library in the O.T. budget plan if the library cannot afford its own subscription.

It would be helpful it state associations subscribed to volumes to be sent with their compliments, to state and city, public and medical libraries—for it is to the public libraries that laymen go for information, and a profession which is not represented there can make no great impression. Many libraries would themselves subscribe to the *Journal* if they had requests to do so.

The *Journal* ought also to be available in medical school libraries, particularly where there are physical medicine departments. State and city chapters and national organizations, such as those of tuberculosis, crippled children, infantile paralysis, cardiac and rehabilitation groups, would in many instances welcome our professional publication. Already there are some individual members of our association who supply the *Journal* to those outside the country who, because of export policies, are unable to send money to pay for their own subscriptions.

We find that some occupational therapy schools and training centers are using the *Journal* for required reference reading—but out of a total school enrollment of approximately 2015, only 462 have the student membership in the national association which will bring them the *Journal.* It is for the schools—the

THE AMERICAN JOURNAL OF OCCUPATIONAL THERAPY

Published bi-monthly by the American Occupational Therapy Association. AJOT Publishing Company, 739 Boylston Street, Suite 129, Boston 16. Editorial Office: 64 Commonwealth Avenue, Garden Suite, Boston 16, Mass.

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PUBLISHER ..... Shepley Cleaves

educators—to decide when, or whether their students should become familiar with professional literature, and through it, the national organization which makes occupational therapy recognized as a profession.

Those who pay their national dues and registration fees automatically aid the association and the *Journal*. Both schools and state associations, by active personal influence and example, can be of inestimable help in strengthening their own and the national organization by encouraging arrears members to become members in Good Standing. It would be hypocritical for us to say we do not recognize that many a therapist, as long as she has her job and as long as the field is short-handed, feels no responsibility toward the national organization without which she would have very little professional status today. Nothing could be more fallacious than to believe that a therapist by herself or one school alone could maintain recognition of the profession and bring about the accompanying demand for therapists in a period when all groups are organized. So to us, a therapist isn't worth her salt who doesn't, while she is practicing her profession, repay in some way the efforts of others who have made her standing and position possible. There are few indeed who cannot afford to invest in their own security in the future of their profession, by paying dues and registration fees. Dues and fees, for example, require 1/192nd part of a $2500 salary.

Except in our own area we cannot make the personal contacts so necessary to a new publication—but you, in your area, can be instrumental both in obtaining contributions and in increasing our circulation. Contrary to the history of a large majority of new publications, the *Journal* is not in debt, but neither it nor the association has sufficient funds to disperse casually a great many gift subscriptions. We can afford, however, to make a special offer which we hope will be helpful to those who aid us in increasing our circulation. For two dollars and a half, we will send a half year subscription (August-December) to those institutions, libraries, schools or associations whose coupons reach us on or before July 15. (See page 127 for coupon) We NEED the backing of every member of the association because it is during the formative years that a magazine becomes established.

SCHOOL SECTION

THE COLLEGE OF ST. CATHERINE

St. Paul 1, Minnesota

SISTER JEANNE MARIE, O.T.R., *Director*

O. T. student and student nurse discuss possibilities of graduated exercise on hand press.

Occupational therapy came to The College of St. Catherine at the request of the students and with the approbation of trustees, administrators, and faculty. Guidance has been afforded its past three years of development by well-known leaders in Boston, New York, Chicago, Milwaukee, Tacoma, and Los Angeles, as well as by those in Minnesota. Full accreditation was granted it by the American Medical Association on June 8, 1947. To date, there have been four graduates; all have found immediate placement. Enrollment for specialization in the qualifications sequence is strictly limited to ten majors a year; this year there are seven majors and two minors. But enrollment in any of the courses of the sequences, as electives, is kept wide open and is deliberately favored. It is the conviction of all concerned that intelligent preparation for aid to suffering humanity is liberally educative.

The whole College helps with the teaching. The twenty-seven students, out of the all-college total of eight hundred fifty, who are enrolled as sophomores, juniors, and seniors—with O.T. as their major—pursue studies in thirty-six classes other than those of their own sequence. The advantage of this scatter is that more powers are challenged, and if an individual finds, even in her fourth year, that she does her best work in another field, she may still major in that field and keep occupational therapy as her minor. There is no-one who would not be benefitted by the point of view of occupational therapy or by its wholesome habits, but there are only a few, perhaps, who should make it their profession. Only the B.S. degree course is offered.

What Is Different About O.T. At C.S.C.

As in all Approved Schools of Occupational Therapy, standards are valued at The College of St. Catherine; essentials are first considerations; integration and sequence are constant objectives. The differences derive from a certain unique combination of resources on—and off-campus: (1) a Rockefeller Foundation endowment of medical courses for women, (2) art and music departments that encourage participation by every college student, (3) psychology popular as a minor, (4) a pre-school demonstration center with fifty-seven children to work with five mornings a week, (5) daily living and learning of religion, (6) in the immediate community — three hospitals that send their student nurses to the College for their laboratory sciences and, in return, admit occupational therapy students to lectures by doctors arranged for their nurses and internes; other hospitals, a school for crippled children, and a curative workshop that permit their directors of occupational therapy to supervise thirty hours of practice during the first quarter of the senior year and to conduct a two-hour conference at the College on their evaluation of this practice; doctors who interpret to the whole College and to families and friends of the students, in a Medical Lectures Series, the applications of occupational therapy in the five fields of its professional service; alumnae who furnish tools and equipment, aid in securing instructors, represent the service at national meetings, and counsel about placement of grad-

uates as well as about admission of new students; (7) a contingency distributed through different States and foreign countries from which students come to the College, and in which—especially from Minnesota to the Pacific—occupational therapy is quite new or as yet not organized. With support maintained from these resources the unique pattern of the program for occupational therapy at The College of St. Catherine, described in its first Special Bulletin, must keep to its motives, if it is to remain effective.

O.T. Motives At Work At C.S.C.

In general, the aims of the College are the aims of each of its departments. Briefly stated in the hierarchy of their importance, these aims are: to help each student to become a saint, a worthy member of a good home, and a community worker. Most graduates attain these goals in reverse order: they earn their living in their chosen professions for from two to five years; ninety-eight per cent of them plan to marry, while two per cent take the vows of Religion; finally, it is hoped, many may realize holiness in their lives, and some may even be recognized as saintly.

Specifically, occupational therapy offers students a new profession to prepare for; in the home, it would cherish the use of all those activities which, having been proved to be of therapeutic value, must also have great promise for prevention of illness or disease; universally, it would try to win more persons to praise God by using more of His gifts in better ways for more good purposes than could be done without it. The College, through occupational therapy, wants to encourage every well person to remember every sick person, to hasten his recovery and to minimize his limitations—working particularly with patients of doctors who acknowledge its need in lightening the tasks of nurses, in developing into habits of suitable work and worth-while recreation, the gains won by physiotherapists, and in promoting the plans of medical social workers for fuller rehabilitation.

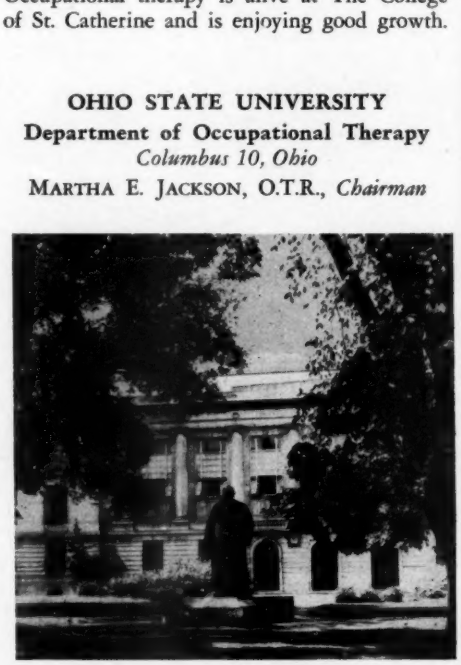
Concretely, the occupational therapy section of the division of community service at The College of St. Catherine is trying out its effectiveness in a Cooperative Project with Ancker Hospital. During scheduled hours the director demonstrates therapeutic exercises with patients for whom doctors' prescriptions are obtained by nursing supervisors; senior students assist with treatments and with records and finally make return-demonstrations; juniors observe and write interpretations of patients' medical disabilities; sophomores prepare treatment media for teaching and testing. Enthusiasm for this project is equalled by that of the occupational therapy club whose members print tickets and programs for other clubs, entertain at whitrling parties, sponsor the Medical Lectures Series, and correspond with students in other Schools and in Clinical Training Centers. Occupational therapy is alive at The College of St. Catherine and is enjoying good growth.

OHIO STATE UNIVERSITY

Department of Occupational Therapy

Columbus 10, Ohio

MARTHA E. JACKSON, O.T.R., *Chairman*



Seventy-five years ago students were first enrolled in classes at the Ohio Agricultural and Mechanical College, an institute which was later to be known as Ohio State University. This year marks the Diamond Jubilee. "Growth through Service" is the theme selected for the anniversary celebrations. This is indeed expressive of the development of the University as it has expanded to meet the ever-growing needs in various areas. It has grown from one college to ten with an increase in enrollment from 17 to 25,000 students.

Now is a fitting time to present the develop-

ment of one of the newer departments on campus which shows how the University has added programs to meet demands for service to the community. The establishment of the department of Occupational Therapy is typical of the way in which the faculties of the University work together in providing opportunity for higher education in needed areas.

In 1941, the President of the University wrote to all faculty members asking for recommendations on how this institution could be of further service during the war years. One suggestion was for the establishment of a program in occupational therapy. This resulted in the University Committee on War Activities appointing a subcommittee made up of representatives of various departments on campus which would be concerned in the development of this professional training and superintendents of several hospitals in Columbus. The group recommended that a program leading to a certificate in Occupational Therapy be established in the College of Education with the possibility of a student obtaining a degree of Bachelor of Science in Education. It further recommended that a specially trained person in the field of Occupational Therapy be appointed to the University faculty to integrate the program.

Early in 1942 the Executive Committee of the College of Education appointed a small committee to prepare a tentative curriculum for occupational therapy and to secure a qualified therapist. This group was later to be known as the Advisory Committee for Occupational Therapy. It was composed of persons in major areas of instruction for occupational therapy and continues to guide the policies of the Department and the development of the program. The Dean of the College of Medicine and the Dean of the College of Education are ex-officio members of the committee—an arrangement which aids considerably in correlating professional training.

In September 1942 a qualified therapist was appointed chairman of the department of Occupational Therapy and students were enrolled in a certificate course. Plans went forward, however, for the establishment of a degree course and in January 1944 the Council on Instructions approved a thirteen quarter course leading to a degree of Bachelor of Science in Occupational Therapy. It was felt that the academic work plus the nine months clinical training should be completed in as near four academic years as possible. The field experience for which college credit is granted is included in the thirteen quarters. The curriculum was accredited by the Council on Medical Education and Hospitals of the American Medical Association in February 1944.

The clinical training is set up on a supervisory basis similar to practice teaching in that a member of the department visits the students during each affiliation. This has been of great value especially in the correlation of the work on campus with the experience in affiliated institutions.

The interest and concern of the faculty of the University in the development of the professional training is exemplified by the fact that courses are offered to occupational therapy students in five of the colleges on campus. In each area where specialization was indicated new courses were planned to meet the need of this group, or existing ones were redesigned to suit our purpose. Because of this the curriculum for the training of occupational therapists has developed steadily and will continue to grow as the Department is ready to expand in order to meet new demands in the profession.

Due to the size of the campus and the difficulty of students to know others in their major field the Student Occupational Therapy Association was organized and officially recognized in December 1942. The purposes were:

1. To further knowledge of occupational therapy among students in the group on campus.
2. To foster a spirit of professional unity among students in occupational therapy.

SOTA has continued to be an active organization and has done much to get the students in all the classes together. Some of the developments of the group have been a SOTA pin and the SOTA Sampler. The pin is a diamond shaped black onyx on gold with a suitable design to identify members of the group and is worn by the students on campus as well as during clinical training.

The SOTA Sampler is a combination student bulletin of the University and news letter of the Ohio Occupational Therapy Association. It is staffed by students who plan one issue

ACCREDITED SCHOOLS OF OCCUPATIONAL THERAPY

and those with Accreditation Pending †

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Chairman, O.T. Department

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Acting Director O.T. Training Course

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1300 University Ave., Madison 6, Wis.
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Technical Director of Course in O.T.

each quarter with the exception of the summer. State association material is collected from representatives in each of the four districts and is included with campus news. It is an excellent means of helping the two groups know each other.

To date we have graduated seventy-one students. We are proud of the fact that fifty-nine per cent of this group are active in occupational therapy. Twenty-two are working in Ohio which is a step forward in the development of treatment programs in a number of hospitals. Once again, through establishment of the Department of Occupational Therapy, Ohio State University has contributed to the service in the community.

FEATURED O. T. DEPARTMENTS

Occupational Therapy and Industrial Accidents of Ontario

By BETH PIERCE, O.T.R.

Assistant Supervisor of Occupational Therapy, Malton Convalescent Center, Malton, Ontario

Ten months of stimulating changes and alterations have taken place since the Workmen's Compensation Board Clinic of Toronto became a suburban canvalescent center at Malton, Ontario. For it was on the first of July, 1947, that the Workmen's Compensation Board of Ontario began to see the realization of a long period of dreaming instigated and urged on by the medical director of the Clinic. The injured working man of Ontario now receives twenty-four hour convalescent care at a center fifteen miles removed from metropolitan Toronto.

For many years the injured man attended the clinic in Toronto from nine to four-thirty each day, then left to eat in restaurants and sleep in Workmen's Compensation Board dormitories and boarding houses. That system proved to have weaknesses, the most glaring being that the claimant was almost entirely on his own for the evenings and could, through ignorance or carelessness, undo the benefits of the day's treatment. The entertainments indulged in often helped to slow down progress and discharges. Special diets could not be catered to nor entertainment provided until this move was made that brought all the men under a common roof.

Every institution has a goal which is constantly before it. The staff members of the Malton Convalescent Center are cognizant that the men under their care must return to work at the earliest possible date with a maximum return of functions and strength in the injured part. For the occupational therapists there is an added and greater stimulus to provide a graded programme of remedial activities that, by the end of the treatment, will require as much muscular effort as the man will need to put forth to do his work. Malton Convalescent Hospital is not a spring-board to further rest or treatment but a spring-board right back into industry.

Few occupational therapy centers have the space or the official encouragement with which the Malton Center has been blessed. Six former hospital wings and an erstwhile canteen are

the present indoor facilities available to the occupational therapists. The whole outdoors is theirs for remedial games, hikes, gardening and heavy laboring activities. The following outline will present a broad picture of the seven distinct sections that make up the present occupational therapy department:

Section A. Carpentry . . . complete with hand tools and foot-powered saws, drills, sanders and lathes.

Section B. Gymnasium . . . for half-hour remedial classes for foot, arm, neck, back injuries and walking disabilities.

Section C. Delorme Room . . . heavy resistance exercises for quadriceps, glutei, biceps, triceps, also exercises for hand grip, dorsi and plantar flexion, inversion and eversion of the foot.

Section D. Remedial Games and Apparatus:

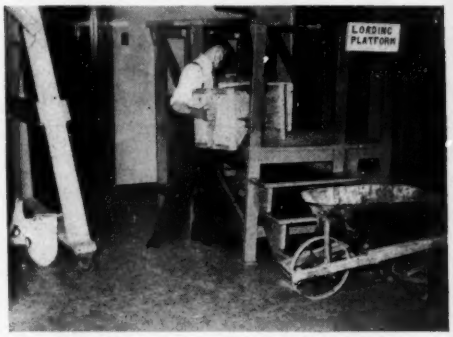
a. Checkers, shuffle-board, darts, ping-pong, bowling.
b. Amputation retraining room.
c. Inverted bicycles and treadles, quadriceps push, sliding seat, tread-mill, wall and overhead pulleys, shoulder wheels, wrist rolls weighted with sandbags.

Section E. Small Crafts: weaving, braided and hooked rugs, knotted belts, leather work, wall murals and painting, pottery.

Section F. Heavy O.T.: painting, wall plastering, bricklaying, cross-cut sawing, railway tie laying, riveting, loading crates and barrels on loading platform, scaffold work, metal and plastic work, pipe-cutting and threading, shovelling.

Theater . . . for general reconditioning P.T. classes.

With the above sections in the occupational therapy department it is possible to provide a programme of graduated activities for a very varied group of patients. These men are not only diversified as to injuries, but also as to work history backgrounds. A study of the new admissions to occupational therapy during the last six months revealed that the "general labourer" provided the largest patient group, with the maintenance men and machinists, press and machine operators, and men employed in the lumber industry following in succession. After classifying the seven hundred and twenty-four claimants discharged from the clinic in the six-month period from the first of July to the last of December, it was discovered that the hand group had been the largest, with the shoulders, feet, knees and legs providing the first five in a twenty-four category analysis. With such a range of injuries and occupational



backgrounds, an imposing array of treatment alternatives must be available in the occupational therapy department.

How is a new patient admitted to the Malton Occupational Therapy Department? The first morning after his arrival at the hospital, he is examined by the director of physical medicine. An occupational therapist and physical therapist are present for all admissions in order to obtain the prescription and objective for the treatment programme. The new patient is then seen by the supervisor of physical therapy who begins to fill out his treatment card by assigning an hour or hours for his physical therapy treatment. The claimant is then directed to the occupational therapy supervisor who completes his card by placing him in suitable sections for treatment.

Illustrated (right) is the green occupational

FORM C 12

CLAIM 41895632

FIRM 6783926

CLINIC TREATMENT RECORD

NAME T.F.G. OCCUPATION millwrite

ADDRESS: HOME 290 Green Avenue CITY Toronto, Ont. PHONE Me 4563

INJURY traumatic amputation of ring finger, right hand

DATE 8/24/47

ADMITTED November 26, 1947 AIDE

CONDITION ON ADMISSION abduction of right shoulder with slight forward flexion in movement is 110°. Forward flexion is 105°. Inward and outward rotation is limited somewhat. Fingers flex to within 2" of the palm. Most of restricted movement is in the medial and distal interphalangeal joints.

OBJECTIVE O.T. to improve active movement of the left arm at the shoulder, increase finger flexion and strength of grip.

PRESCRIPTION

9 A.M.	C - Delorme Gripper	1 P.M.	D
9.30	B - Arm Class	1.30	B
10 A.M.		2 P.M.	F
11 A.M.		3 P.M.	A

RESTRICTIONS None.

LQ

MEDICAL DIRECTOR

PROGRESS NOTES AND SUBSEQUENT ORDERS

DATE Nov. 26/47 Claimant works at the company as a millwright - setting up and dismantling heavy machines. Will need a strong reliable hand and shoulder for this work. T.S.

therapy sheet which is completed following the admission examination. Under "Prescription" is outlined the time-table which the supervisor of occupational therapy has drawn up during her interview with the new patient. She has the picture of the extent of the injury from the doctor's examination, she has the doctor's objective for treatment and finally she has the man at hand to interrogate regarding the work to which he plans to return as soon as he is fit again. With these facts the supervisor is able to draw up a treatment schedule which is entered on the card (illustrated) that is carried with the patient to all his treatments.

NAME T.... F.G. CLAIM 418956-32 C16

8.00 a.m.	1.00 p.m. B F3d 3
9.00 a.m. C 9.30 B	2.00 p.m. F
10.00 a.m. } Physio	3.00 p.m. A
11.00 a.m. }	6.30 p.m.

For two weeks the claimant continues with this schedule unless in the interim the occupational therapist feels that the man would benefit from a change in programme. After a fortnight, the claimant is examined by the assistant director of physical medicine. With the doctor in the examining room is the man's complete file with reports from all departments of the hospital concerned with the case, and a separate report from each section of the occupational therapy department. Following the examination, the doctor suggests changes, step-ups, or deletions from the existing schedule, as they appear necessary. If the claimant is approaching the stage where a discharge may be possible, the doctor will request that the various sections estimate the ability of the man to return to his former work, or make suggestions as to alternative jobs which the man might be capable of filling. At the same time, Section F, where all heavy occupational therapy is housed, is instructed to run a "work-test" to evaluate his strength and endurance on a programme which resembles as closely as possible his former occupation. In order to present the work situations, it is necessary to have plaster for walls, bricks for laying, crates and barrels for loading, and wheel-barrows, pipe-cutters and shovels to use. This section provides for the advanced stages of the patient's treatment, and gives every man a chance to see for himself whether or not he is physically able to return to work. A section resembling the one described is essential in any convalescent center for the injured working man.

The whole atmosphere of the Workmen's Compensation Board Convalescent Center is one of stimulating alertness. Occupational therapy is not based on "arbitrary rules that decide what is and what is not occupational therapy," but instead is in a "constant state of change ready to devise and invent new forms or modifications of old to suit an ever new set of conditions."[1]

It is not only in the field of industrial accident rehabilitation that occupational therapy must be stimulated to move ahead, but every branch of the profession should and must accept the challenge to advance.

[1]Storms, H. D., *Occupational Therapy in Treatment of Industrial Casualties*, Canadian Journal of Occupational Therapy, April, 1943.

"The Street Car on the Roof"

By ELLA V. FAY, O.T.R.
Director, Occupational Therapy, Cook County Hospital, Chicago, Illinois

The year 1947 was an eventful one at Cook County Hospital, as this was the 100th anniversary of the founding of the hospital. This, the largest hospital in the world, has a capacity of 3400 beds. With this number of patients to care for, it means constant effort to provide the best possible means to serve these patients. Thus the Occupational Therapy and Physical Therapy Departments were enlarged to four times the original space and brought side by side on the seventh floor of the main building. They are officially known as the Department of Physical Medicine; the Occupational Therapy section occupies the entire south wing of the unit. The main treatment room looks like a large sun porch with windows on three sides and outside is an open roof where the patients may enjoy sunshine as an added means of healing.

Plans for the new department included practical equipment to meet the needs of the treatment program. Since most patients must travel to and from the hospital by surface line it seemed essential to have a street car on which they could learn to get on and off with confidence before leaving the hospital.

When the Chicago Surface Lines was contacted with a request for an old street car, their engineers were sent to study and discuss the situation with the hospital staff. They decided that an old car would be too heavy for the roof and therefore that a facsimile should be built of lighter material. In a few weeks the car was brought up in sections and assembled. It consisted of a standard front platform, and two extra seats inside, where the patient can rest before attempting to alight from the car. To make it practical for timing and response, the bell which the conductor uses to stop and start the car, and the motorman's foot bell, were installed. The car was finally marked in large letters "Cook County Special, No. 016." It was painted a bright red with yellow trim and can be seen for some distance.

The arrival of the car caused considerable interest and excitement on the part of our neighbors, many of whom had not called on us for years. They saw it across the roofs and lost no time in visiting us to find out what was going on.

To obtain material for a feature article in the employees' bulletin "Surface Service" the Surface Lines sent photographers to take pictures of the patients at practice on the car. The article enabled employees to appreciate the various means of assisting handicapped people. Several newspapers also took pictures and wrote feature stories about the car and its purposes.

The important thing of course is the value to our patients who, with crutches, canes, braces or prostheses, must eventually return home via the street cars. It has been particularly helpful to have the car on the open roof where the patients are exposed to all kinds of weather. To the special practice in balance, which is required to face wind, rain and snow, must be added the further experience of coping with extra wraps and heavy clothing.

Some patients, of course, lack confidence in making their first attempts but they are extremely interested in the help which the car can give them, and word has gone from one patient to another that we have had no accidents. As a whole, patients recognize the significance of assignment to the car as a step in

progression toward discharge. One of the first patients who learned to board the car was a woman over sixty who, after a left leg amputation above the knee because of a diabetic condition, was learning to use her prosthesis. She had no home but could go to a convalescent home if she could care for herself. After eight times on the car she could manage alone.

The patients range in age from twenty through seventy. The following are a few of the disability types with which the car has played a part in rehabilitation: alcoholic polyneuritis, fracture of lateral tibial plateau, vitallium cup arthroplasty of the hip, intertrochanteric fracture of right femur, arthritis, locomotor ataxia, hemiplegia (due to trauma or vascular accident), amputees with prosthesis.

Art in the O. T. Department of a Veteran's Neuro-Psychiatric Center

By IRWIN FRIEDMAN
Occupational Therapy Aide, Sawtelle Veteran's Hospital, Los Angeles, Cal.

In the terminology of the modern neuropsychiatric hospital, the age-old maxim "Gold is where you find it," would seem out of its element and foreign to its surroundings. Strangely enough, however, we have found it to be most applicable to our art program. The unalloyed pure gold of talent is discovered each day in the Art Studio of our occupational therapy shop in a quantity and of a quality that is a constantly pleasing surprise.

As instructor in the studio I have found that a set course of formal instruction is not indicated, and have instituted in its stead a working program based on guidance, suggestion, and inspiration. It has proved in the majority of cases very successful.

With the exception of grilled windows, our Art Studio gives no indication that it is within the confines of a mental hospital. Music, flowers, and a general air of informality lend a feeling of normalcy to the over-all picture, and are most conducive to creative expression and relaxation among our patients.

Our walls are lined with bulletin boards which form a pleasing background for finished work and it is evident that a feeling of pride and accomplishment is fostered by this display. This in itself is a normal reaction, as we all know that to have the fruits of our endeavors seen and appreciated by others is stimulating, and inspires us toward greater efforts.

The execution of our program demands the complete cooperation of the entire hospital staff concerned. The referral system as practiced in our hospital insures the utmost in results, as any aptitudes toward special types of work are set forth on the prescription form, and as treatment progresses toward occupational therapy, this form follows the patient. Treatment aims and occupational interests are clearly set forth, enabling the therapist to schedule a clearly defined program best suited to the patient's needs.

External stimulus is used where poverty of thought or imagination is present. I have found that once a contact with reality has been established, the patient when he again enters the studio, is eager to complete the project. Even in cases of extreme regression, satisfactory responses are evident.

Due to prevailing exigencies, it is not possible to use living models, and with each patient in a varied state of progression, supplying a model becomes a problem. Our patients are of such widely different types that to set up individual models would infringe greatly on the time allotment. To alleviate this situation, we keep a widely diversified inspirational file, containing colored and black and white reproductions of several applicable subjects—for example: flowers, animals, landscapes, design, architecture, and other suitable material.

Individual adaptation rather than copying is encouraged, and that this method insures results has been proved by a wide interpreta-

tion of the same subject by different patients.

Psychiatrists working in close conjunction with the department, have found that certain types of art work are of great value in diagnosis and are constantly in touch with our department so as to keep a close check on patient progress. In the Art Studio, all types of expression are encouraged as a method of projection of the subconscious so that the psychiatrist is able to deal with and prescribe the type of therapy indicated by the ideas set forth by the patient. Delusional and fantastic work, however, is not fostered beyond the above mentioned point, and a trend toward reality and concrete objectivity is the goal we set for our patients.

Recently a great deal of patient interest and enthusiasm was stimulated by participation in a nationwide art exhibit and the four prizes awarded our patients' work indicated that the quality of work emanating from our neuropsychiatric hospitals need not be delusional and hallucinatory, but can approximate similar work of art and trade schools.

All patients working in the studio are voluntary, and are representative of all types of mental illness. The work is as varied as the type of aberration, and all contribute to the changing color of the studio's pattern. Due to the uninhibitive quality of the work an infinitely varied expression of creativity is manifested.

Patients with art school training find that they can, in a measure, continue whatever phase of the work they were engaged in prior to hospitalization. Those who have had no training find it a proving ground for latent talents that can be projected without fear of unkind criticism and ridicule.

Progress is the chief aim of our occupational therapy art program and, working under the aegis of Medical Rehabilitation Service, it has proved a workable success,—for many of the patients after leaving the closed wards are eager to return to the studio for further work. Arrangements have been made with Rehabilitation for various tests so that we are able to watch the patient progress through prevocational work and into the job best suited to him, or if indicated, to art school.

Contact with discharged patients has proved that the period spent in our art studio was well used. This deeply gratifying knowledge is most encouraging and is an incentive to us to go farther afield in our work.

Miss Barbara Stowe, Chief O. T. at London's St. Thomas Hospital, will be sent this box being packed by members of the Mass. Assn. for O. T. Miss Stowe will disperse these materials in England. (photo courtesy Russell T. Loesch)

O-TEASERS

1. What are the principle steps in rehabilitation?
2. What is meant by "development guidance" in the area of pediatrics?
3. How long has England had an official association of occupational therapists?
4. What is the number one cause of death of the school age child?
5. How may the projective technique in psychiatry be used in occupational therapy?
6. Explain the difference between dystrophy and atrophy of a muscle.
7. Is it true that mental disease was probably less prevalent in ancient days?
8. Does true epilepsy cause mental deterioration?

See page 124 for answers.

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**Member of Executive Committee*

THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

33 West 42nd Street - New York 18, N. Y.

CONSTITUTION

(Revised November 3, 1947)

ARTICLE I

NAMES AND OBJECTS

Sec. 1. The organization shall be called the American Occupational Therapy Association.

Sec. 2. The objects of the Association shall be to promote the use of occupational therapy, to advance the standards of education and training in this field, to promote research, and to engage in any other activities that in the future may be considered advantageous to the profession and its members.

ARTICLE II

MEMBERS

Sec. 1. Members shall be divided into six classes: 1. *Active:* those who are registered occupational therapists in good standing, who are or have been actively engaged in the use of Occupational Therapy; and when there is a state or regional association recognized by the A.O.T.A., they must be active members of their state or regional association. 2. *Fellows:* those who by virtue of professional or community status can relate Occupational Therapy to the public need. 3. *Students:* those in training in an accredited school of Occupational Therapy. 4. *Associates:* those persons interested in promoting Occupational Therapy, but not eligible for active membership. 5. *Sustaining:* those who are eligible as active or associate members but whose interests in the objects of the Association prompt them to larger contributions to its support. 6. *Honorary* life membership may be conferred upon those who have performed distinguished service in the field of Occupational Therapy.

Sec. 2. 1. *Active* members and such sustaining members as are eligible for active membership may vote for and be eligible to any office of the Association. 2. *Fellows* may vote in the election of officers and may be elected to serve as officers or Board members. They shall be appointed by invitation of the Membership Committee to serve for a period of three years, subject to reappointment. 3. *Students* may not vote in the affairs of the Association but may be invited to serve as members of committees without vote. 4. *Associates* shall have no vote in the election of officers and are not eligible to any office of the Association but may be invited to serve on committees. 5. *Sustaining* members may serve on committees but may not vote for or be eligible to any office of the Association unless eligible to be active members or fellows. 6. *Honorary* members may serve on committees but may not vote for or be eligible to any office of the Association.

Sec. 3. 1. The Membership Committee shall consist of three members appointed by the President of the Association. 2. The Membership Committee shall pass on all applicants for active, student, and associate membership or offer invitations to membership and determine the status of each candidate in terms of classes of membership. 3. Membership can be considered by the Membership Committee only upon receipt by the Executive Secretary of an application from a candidate. 4. The nominations for Fellows may be presented by any member of the Association to the Membership Committee, which in turn shall present such nominations to the Board for final approval. 5. Fellows are not required to pay dues in view of the contributions they make to the Association by virtue of their status, but may become contributors.

ARTICLE III

OFFICERS

Sec. 1. The officers of the American Occupational Therapy Association shall be a President, First Vice-President, Second Vice-President, and Treasurer elected by the members at the annual meeting. They shall serve a three-year term. The President and Vice-Presidents may not serve more than two consecutive terms. They shall assume office at the final session of the annual meeting at which they are elected.

Sec. 2. The President shall preside at all meetings of the Association, shall be chairman of the Board of Management, and ex-officio a member of all committees. He shall have power to sign all written obligations of the Association, and to appoint chairmen and membership of all committees. The First Vice-President—or, in his absence, the Second Vice-President—shall discharge the duties of the President in case of his absence or during a vacancy in the office.

Sec. 3. Under the direction of the Board of Management and the Executive Committee, the Treasurer, who shall be bonded, shall direct and be responsible for the collection of all dues and for keeping the accounts of the Association and disbursing the funds. He shall report at the annual meeting and submit a financial statement properly audited.

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Subcommittee on Bedside Projects
Borghild Hansen, O.T.R., Chairman
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N. Meryl Van Vlack, O.T.R., Chairman
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Subcommittee on American Journal of O.T.
Charlotte D. Bone, O.T.R., Chairman
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Ohio ..... Minnie Fevold, O.T.R.
Oregon ..... Marjorie Englehardt, O.T.R.
Pennsylvania ..... Ruth Greve, O.T.R.
Pennsylvania, Western ..... Bessie Clark, O.T.R.
Texas ..... Lenore Brannon, O.T.R.
Virginia ..... Mary Junkin, O.T.R.
Washington ..... Edna-Ellen Bell, O.T.R.
Wisconsin ..... Ruth Bell, O.T.R.

ARTICLE IV

Board of Management

Sec. 1. The affairs of the Association shall be managed by a Board of Management to consist of the officers, six members of the House of Delegates and thirteen other persons, eight of whom shall have been active members of the Association for one year previous to their election. The other five may be active therapists who have been active members for one year, or Fellows. Those Board members other than the officers and the six members from the House of Delegates shall be elected by the membership for a three-year period, and no person shall serve more than two consecutive terms. Four shall be retired one year, four the following year, and five every third year. The executive shall act as secretary for the Board and for the Association, and shall issue orders for all meetings of the Board of Management. There shall be an annual meeting and a mid-year meeting, the dates of which shall be October and March unless otherwise fixed by the Executive Committee of the Board.

Sec. 2. Upon the day before and at the close of the annual meeting, the Board of Management shall meet to receive and act upon reports of officers, committees and recommendations of the House of Delegates. Special meetings may be called by order of the President or at the request of five members of the Board of Management or one-third the members of the House of Delegates. A majority of its members shall constitute a quorum at any meeting, but any members unable to be present may be represented by proxy. This may be used for guidance and discussion but does not constitute a vote.

Sec. 3. At each annual meeting, the Board, through its executive, shall submit a report of the affairs of the Association, with the expenditures of the past year and an estimate for the expenses for the coming year and shall report at other times, if called upon to do so, by a majority of all members of the Association.

Sec. 4. In emergency situation, the President of the Association may call for a vote by mail by the Board of Management, the Executive Committee, the House of Delegates or the Association on matters that have been discussed in regular meeting or in special session of any of these bodies.

ARTICLE V

Executive Committee

Sec. 1. The Executive Committee shall consist of the President, one of the Vice-Presidents, the Treasurer, and four members of the Board of Management, one of whom shall be a member of the House of Delegates serving on the Board. They shall be appointed by the President. A quorum shall consist of four members of the Committee.

Sec. 2. The members of the Board appointed to the Executive Committee normally shall be appointed to a three-year term. At the time of the creation of the first Executive Committee, two members shall be appointed to the three-year term, one member to a two-

year term, and the fourth to a one-year term. Those so appointed shall be followed at the proper time by appointments of three years.

Sec. 3. No Board member shall be appointed to the Executive Committee for more than two successive three-year terms.

Sec. 4. The Executive Committee shall conduct the affairs of the Association between meetings of the Board and shall carry out the aims and instructions of the Board of Management and shall report regularly to the members of the Board the actions taken at each meeting.

Sec. 5. The Executive Committee shall direct the collection, disbursement and custody of funds.

Sec. 6. The Executive Committee is empowered to employ such personnel and make such expenditures within available resources as may be required to complete or carry out the functions of the Association and policies of the Board.

Sec. 7. The Executive Committee, subject to the approval of the Board, empowered to employ an executive who shall be responsible to the Executive Committee and the Board, and who shall attend the meetings of the Executive Committee but shall have no vote in its affairs. The Executive shall act as the business manager for the Association and shall perform such duties as the Executive Committee may delegate.

ARTICLE VI

House of Delegates

Sec. 1. A State or Regional Group composed, wholly or in part, of practicing registered therapists, shall be considered eligible for affiliation with the American Occupational Therapy Association. Active members of affiliating State and Regional Associations eligible for active membership in the American Occupational Therapy Association must become active members of the American Occupational Therapy Association and pay the established membership fee.

Sec. 2. There shall be a House of Delegates to act as a recommending body, to suggest policies, and to present to the Board of Management for action such other matters as shall be brought to their attention. They shall meet yearly at the Annual Meeting and at such other times as it deems advisable. A special meeting may be called at the request of the Board of Management or one-third of the members of the House of Delegates. Only such business as stated in the call shall be transacted.

Sec. 3. The House of Delegates shall be composed of Delegates elected by the approved constituent State or Regional Associations. Each constituent association shall be entitled to elect one Delegate and an alternate. While both the Delegate and the alternate may attend meetings, only the Delegate—or the alternate acting as the Delegate—may vote. The Delegate shall be elected, and notification of his election—with his credentials—shall be sent to the secretary of the House of Delegates within thirty days after the annual meeting terminating the predecessor's term. The person so elected must have been a registered Occupational Therapist and an active member of the American Occupational Therapy Association for more than one year before the date of his election. The Delegate shall serve for three years, including the first annual meeting following his election, and shall continue to represent this Association until a new Delegate is elected. He may be reelected for only one succeeding term. At each annual meeting, all Delegates must present credentials, satisfactory to the Committee on Credentials of the House.

Sec. 4. The Committee on Credentials shall consider and recommend to the annual meeting any State or Regional Associations that in the future may be considered qualified for affiliation with the American Occupational Therapy Association.

Sec. 5. The House of Delegates shall annually elect a Speaker or Presiding Officer, a Vice-Speaker, a Secretary (who shall act as Chairman of the Committee on Credentials) from the group of Delegates who have served at least one year prior to election. They shall hold office until the close of the next annual meeting of the House of Delegates. Any Association unable to send a Delegate may be represented by a written certified statement of opinion from the Association covering each item of the agenda. This may be used for guidance and discussion, but does not constitute a vote.

Sec. 6. One-third of the House of Delegates shall constitute a quorum.

Sec. 7. The House of Delegates shall elect for representation on the Board of Management six persons from its membership. Their term shall be two years, three retiring annually.

Sec. 8. Members of the House of Delegates elected to the Board of Management shall serve a two-year term. If for any reason a Delegate serving on the Board is unable to complete his term, his place shall be filled by another Delegate appointed by the Speaker of the House.

ARTICLE VII

Committees

Sec. 1. The Board of Management shall have the power to create such standing Committees as they deem advisable.

Sec. 2. There shall be a Registration Committee of five members to pass on the eligibility for registration with the Association of qualified Occupational Therapists.

ARTICLE VIII

Nominations and Elections

Sec. 1. There shall be a Committee on Nominations to prepare a ticket of nominations consisting of one or more candidates for each office to be filled, and who have consented to serve if elected. The Committee on Nominations shall request from the state delegates and members of the American Occupational Therapy Association

a list of names of persons qualified to fill vacancies in office. It is recommended that the Board be made up of representatives of various fields of Occupational Therapy and that there be geographical distribution of the members. The Committee shall prepare the ballot to be mailed to members at least two months previous to the annual convention.

Sec. 2. The ballot shall be marked by voting members of the association and returned to the National Office within one month of the date sent, at which time the elections shall be closed. The Nominating Committee or representatives appointed by them shall count the ballots. The results of the election to be announced by the Nominating Committee.

ARTICLE IX

ETHICS AND DISCIPLINE

Sec. 1. The members of the American Occupational Therapy Association shall work only under medical supervision or direction.

Sec. 2. The members of the American Occupational Therapy Association shall not advertise.

Sec. 3.

a. Membership in the American Occupational Therapy Association may be suspended at any time by a majority vote of the Executive Committee for malpractice, or for conduct unbecoming a member of the Association.

b. Complaints or charges of this character against a member must be referred to the Executive Committee in writing, signed by the complainant. Notice of the charge shall be sent to the accused in writing and a date set for the hearing and defense of the same. The date shall not be less than thirty days after such notice.

c. Failure to be present at the trial without an excuse satisfactory to the Executive Committee shall be deemed to be acknowledgment of justice of charges.

d. Expulsion shall require the unanimous vote of the Executive Committee. The disciplined member shall be notified of the Committee's action.

e. The Executive Committee may reopen such a case when in its opinion new and pertinent facts are available.

ARTICLE X

DUES

Sec. 1. The annual dues and the amount of dues receivable from the State and Regional Associations shall be determined by the Board of Management.

Sec. 2. Any member who is in arrears for dues for more than the current year shall be automatically dropped from membership in this Association.

ARTICLE XI

AMENDMENTS

Sec. 1. This Constitution may be amended by a two-thirds vote at any annual meeting if notice and copy of proposed changes have been sent to each member of the Association thirty days previously, and if the proposed amendment has been approved by the House of Delegates and the Board of Managements.

Sec. 2. A certified copy of the accepted amendment shall be filed with each state and regional association and printed in the following current issue of the official publication.

ARTICLE XII

PARLIAMENTARY AUTHORITY

Sec. 1. Robert's Rules of Order shall be the Authority of the American Occupational Therapy Association on all matters not covered by the Constitution, By-Laws, Resolutions or Rules.

BY-LAWS

Sec. 1. The by-laws may be ruled and amended at annual meeting by a majority vote of those present.

ANNUAL REPORTS

PROCEEDINGS OF THE MEETINGS OF THE HOUSE OF DELEGATES

November 2, 3, and 4, 1947

These minutes are numbered in accordance with the items on the agenda. Shifts in sequence were made in the agenda because of the need of making recommendations to the Board for its approval at the first meeting.

1. Roll Call

Colorado—Josephine Davis
Connecticut—Bertha J. Piper
District of Columbia—Violet Corliss
Hawaii—Esther Pyun
Illinois—Isabel March
Indiana—Edna Faeser
Iowa—Marguerite McDonald
Kansas—Myrl Anderson
Maryland—Muriel E. Zimmerman
Massachusetts—Jane Merrill
Michigan—Marion R. Spear
Minnesota—Borghild Hansen
Missouri—Dorothy Flint
New Jersey—Naida Ackley
New York—Mrs. Harriet Tiebel
Northern California—Mary Booth
Ohio—Martha Jackson
Oregon—Marjorie Engelhart
Pennsylvania—Clare S. Spackman
Southern California—Elsie Geerts
Texas—Lenore Brannon
Virginia—Represented by opinion
Washington—Edna Ellen Bell
Western New York—Represented by opinion
Western Pennsylvania—No response
Wisconsin—Ruth Bell

New Associations Admitted to the House of Delegates

Kentucky, Northern New England (Maine, Vermont, and New Hampshire), Oregon.

11. Reports to the House from:

A. The President of the A.O.T.A. Mrs. Kahmann greeted the House. She expressed her appreciation of the fine work done by the House of Delegates and the local associations. She asked each delegate to express her appreciation to her association.

VII. Admission of new associations.

Miss Edna-Ellen Bell, Chairman of the Committe on Credentials, then presented the three associations requesting affiliation: Kentucky, Oregon, and Northern New England (composed of Maine, New Hampshire and Vermont). The Committee recommended that each of these associations be admitted. Accordingly, *motions were passed* admitting each of these associations to the House of Delegates. This brought the number of affiliated associations to twenty-eight.

II. Reports to the House from:

E. The Treasurer of the A.O.T.A. The Report of the Treasurer was read. It supplemented the annual financial statement previously sent to all delegates.

IX. Discussion of the following:

C. Presentation of the Budget for the next fiscal year.

As the House had requested that the budget for the coming year be presented to them, this was done. After discussion, *it was voted*: That the House recommend to the Board that the treasurer be instructed to present a layman's summary of the yearly financial report to the House of Delegates and to the membership of the association by publication in AJOT. (Ed.—see December 1947 issue.)

Board action: Approved.

II. Reports to the House from:

B. The Executive Secretary.

C. The Educational Field Secretary.

The reports of the Executive Secretary and Educational Field Secretary were omitted because they would be presented at the Annual Meeting. Miss Messick and Lt. Lund reported on the Army Program, Miss Meyers on the Veterans and Miss Gleavé on Clinical Training.

F. The Constitution Committee.

A letter was read from Miss Eleanor Kille requesting consideration of the position of occupational therapists employed in such institutions as schools for mental defectives and penal institutions. A special committee was appointed to consider the problems.

The House made the following recommendations:

That Article IX on Ethics be approved as presented but that the Board pass the following motions:

That Article IX be interpreted to mean that occupational therapists employed in such institutions as schools for mental defectives, child guidance clinics and prisons be permitted to work under either medical consultation or clinical psychologists. However, it is recommended that whenever possible a medical advisory committee be set up and that this committee approve the occupational therapy program.

That the mechanics of voting by mail be worked out by the Nominations Committee.

It was voted: That the House approve the changes in the Constitution as recommended by the Committee, with the proviso that the requested recommendation be passed by the Board.

Board action: Constitution approved; recommendations passed.

Annual Meeting action: Constitutional changes approved.

III. Moving site of A.O.T.A. office. The moving of the site of the National Office was then brought up for final action. A summary was presented of the voting on this throughout the year. (See past letters to the Delegates). Both the Board and the House have approved the moving of the office to the Mid-west. The Executive Committee was empowered to make the final study and decision. Study showed considerable variation in: 1) cost of moving; 2) office space available; 3) secretarial costs; 4) housing. If the office were moved to Chicago, expenses would be increased. Other Midwest cities such as St. Louis, Milwaukee, Indianapolis and Detroit showed a lower cost of living index. However, it was felt that if the office were moved, it should be to Chicago because of the valuable contact with other allied national associations whose offices are primarily either in New York or Chicago. The

move to Chicago was felt to be inadvisable at the present time because of lack of desirable office space and the cost of living index.

It was voted: that the National office be moved to Chicago in the summer of 1949 and that action be taken to implement this not later than January 1949.

Board action: approved.

IV. *Raising Registration and A.O.T.A. dues $2.00 each.*

It was voted that: Registration and A.O.T.A. dues shall be raised $2.00; i.e. A.O.T.A. dues from $6.00 to $8.00 and Registration fee from $3.00 to $5.00.

Board action: Approved.

V. *Billing of A.O.T.A. and Registration dues at same time from National Office.*

It was voted: That A.O.T.A. membership dues and registration fees be billed at the same time through the National Office.

It was requested that the Treasurer of each state or regional association be notified and that mechanics be set up for informing each association of those who had paid their A.O.T.A. dues.

Board action: Approved.

IX *Discussion of the following*:

A. Publishing AJOT monthly and employing full-time editor. The monthly publication of AJOT and the employment of a full time editor was then discussed. It was felt that at present this was not financially feasible. However, it was felt that Miss Bone should be recompensed for her services.

It was voted: That Miss Bone be adequately recompensed for her editorial services.

Board action: Approved.

The formation of the Nominating Committee for the House was then discussed. The only three persons eligible were appointed: Miss Mary Booth, Chairman; Miss Ruth Bell, and Miss Clare Spackman.

The place for the 1948 Convention was then discussed. New York City, Hotel Pennsylvania, September 7-11, was the most satisfactory possibility.

It was voted that: New York City be accepted as the location for the 1948 Convention and that an earlier date than September be considered if possible.

VI. *Report from Secretary of House of Delegates and*

VIII. *Discussion of the Formation and Function of the House.*

The meeting was then turned over to Miss Edna-Ellen Bell, who presented the recommendations of the Committee on Credentials, with regard to the constitutions of the present associations.

Recommendations for Constitutions for State and Regional Associations:

1. We recommend that clauses with regard to active and associate membership be patterned after the Constitution of the A.O.T.A., and "registration" with the A.O.T.A. constitute the requirement for active membership in the state and regional associations.

2. We recommend that all constitutions provide for the election of the delegate and alternate.

3. We recommend that provision be made within the constitution and by-laws for the delegate and alternate to serve with the President and other officers as members of the Executive Committee or Board of Managers.

4. We recommend

a. That all state and regional associations include an article on membership in their respective constitutions and by-laws.

b. That classification and final approval of new members be delegated to the membership committee or to the voting membership at large.

5. Student membership, if mentioned, should be clarified. We recommend the wording "accredited and approved schools" be used instead of just "accredited schools" in the constitutions.

The Committee on Credentials suggests that the several states carefully review their constitutions. At present there appears to be conflict between the constitution proper and the by-laws, and therefore it would seem that legal consultation would be advisable when conducting the review.

These recommendations were approved as presented.

The Constitutional errors of each association were then presented. (Each delegate was given a copy.)

Miss Bell then presented further recommendations of this committee, as follows:

1. It is recommended that the appointment of the nominating committee be inserted on the agenda immediately following roll call.

2. It is recommended that the admission of the new state and regional associations be an early consideration and previous to the Reports to the House.

3. It is recommended that evening sessions of the House of Delegates be terminated by 11 p.m. and any unfinished business at hand be considered at an additional meeting.

4. It is recommended that members of the Association be allowed within the sessions of the House but with the provision that closed sessions may be called at the discretion of the membership.

5. It is recommended that the Speaker of the House be responsible for a stenotypist at the Annual Meetings of the House of Delegates.

6. It is recommended that a standard credentials form be adopted for permanent use by the House of Delegates.

7. It is recommended that responsibility for adequate meeting space and identification cards be allocated to the delegate of the state in which the convention is convened.

8. It is recommended that archives for the House of Delegates be established in the office of A.O.T.A.

It was voted: That these recommendations be approved.

Not on the agenda

Discussion of the reorganization of the National Office because of Mrs. Cobb's resignation then ensued. The Delegate Board Members were instructed in regard to this matter. Meeting of the House adjourned.

SECOND MEETING OF THE HOUSE OF DELEGATES—Nov. 3, 1947

Miss Spackman reported the action of the Board on recommendations presented.

Suggestions were then requested for the time and place for the 1949 Convention. The Board requested the Delegates to obtain suggestions from their associations. The House suggested the latter part of August, Mid-west location.

VIII. *Discussion of the Formation and Function of the House of Delegates* (continued):

The manual of Rules and Procedures for the House of Delegates was presented. This had been mailed to all Delegates for Study prior to the meetings of the House. This will be presented in corrected form, embodying the recommendations presented and approved by the House.

The House recommended that this manual be included in the Handbook and published in AJOT.

Board action: Approved.

IX. *Discussion of the following*:

B. Method of transferring membership from one State Association to another.

The problem of a member of one local association transferring to another was discussed.

It was voted: That regional or state associations adopt the policy of courtesy transfer of membership. The Treasurer of the association which the therapist is leaving should sign a blank authorizing the transfer, said blank to be presented to the treasurer of the other association. To facilitate uniformity, the House wishes to ask if the National Office would print such a blank, which could be purchased by the associations. (The Secretary of the House will prepare the blank.)

Board action: Approved. The Board requested that a duplicate of the blank be forwarded to the National Office to aid in keeping the files up to date, inasmuch as members frequently fail to inform the Office of change of address.

It was voted: That all affiliating associations should have the payment of dues cover the calendar year, i.e., January 1-December 31.

C. *Development of Placement Service of the A.O.T.A.*

Discussion was held regarding the advisability of further developing the placement service of the National Office. The general feeling was that this should be done as much as possible.

D. The advisability of holding A.O.T.A. Convention jointly with other associations.

It was voted: That the Permanent Convention Committee study the advisability of occasionally holding the AOTA Convention jointly with other associations.

Board action: Approved and referred to Permanent Convention Committee.

E. O.T. representation on planning committees of such organizations as the American Hospital Association and other professional organiza-

tions.

It was voted: That continued and greater effort be made to obtain O.T. representation on planning committees of such organizations as the American Hospital Association.

Board action: Approved and referred to the Executive Director.

F. The function and qualifications of rehabilitation directors and their effect on occupational therapy.

It was voted: That a study be made of the functions and qualifications of rehabilitation directors and their effects on occupational therapy. It was suggested that this matter be considered with the N.R.A. and Council on Rehabilitation and the Trudeau Society. The House also wished to express its interest in the development of adequate tuberculosis training for O.T. students.

G. Advisability of permitting maintenance of registration of occupational therapists when not actively practicing O.T. and of requiring refresher courses or re-examination for therapists returning to the field after a period of inactivity.

It was voted: That the Registration Committee be asked to study the matter.

Board action: Referred to the Registration Committee.

H. Establishment of a policy for recognition of outstanding service to the profession and association.

This was discussed and it was felt that there definitely should be such a procedure but that this should be determined by the Committee on Rules and Procedures.

Subjects I, K, L, and M were then withdrawn from the agenda by the delegates requesting their discussion.

J. Caps—should a uniform cap be established for civilian wear?

This was discussed. Many felt that this was a school problem or up to the hospital.

A motion was made and seconded that a uniform cap for civilian wear be adopted by the Association and that it be left up to the discretion of the individual department whether it be worn. Motion voted down.

A motion was made and seconded that caps be worn in civilian hospitals but that this should be a school cap and not an Association cap.

Discussion: The house cannot make such a requirement of schools. Motion voted down.

Meeting adjourned.

THIRD MEETING OF THE HOUSE OF DELEGATES—Nov. 4, 1947

Following the roll call Miss Spackman read the recommendations to be presented to the Board. *These were approved.*

X. *House election of new officers and Board representatives.*

The elections of the House of Delegates were then held.

Results:

Speaker.....Mrs. Harriet J. Tiebel

Vice-Speaker.....Miss Dorothy Flint

Secretary.....Miss Edna-Ellen Bell

Members on the Board: Miss Bertha Piper—completing Miss Morse's term confirmed, Mrs. Harriet J. Tiebel, Miss Elsie Geerts, Miss Lenore Brannon.

As there had never been a ruling regarding the percentage vote to carry an election in the House, *it was voted* that the majority be accepted.

IX. *Discussion of the following*:

N. Possibility of Life Memberships in A.O.T.A.

Each delegate was to inquire whether any of their members were interested in Life Membership.

II. *Reports to the House from*:

G. Delegates—special state and local problems were then discussed.

A request was made that money be allotted in the A.O.T.A. Budget for the preparation of a good exhibit for display at the conventions of allied professional groups.

New Business:

The *House concurred* in Miss Edna-Ellen Bell's motion that the House express an interest in adequate tuberculosis training. This motion was added to that concerning rehabilitation directors.

Meeting adjourned.

CLARE S. SPACKMAN, O.T.R.
Retiring Speaker

DELEGATES DIVISION

Dorothy L. Flint, O.T.R., Editor

MICHIGAN

Marion R. Spear, O.T.R., Delegate-Reporter

During the year 1947 the Michigan Association held two State meetings. Both meetings were held in Detroit, the first one in June in connection with the Michigan Chapter of the American Physiotherapy Association, and the second one in October immediately following the meeting of the Michigan Mental Hygiene Association.

The State meetings were both of two days' duration and were well attended. In addition to the fast-growing membership which we hope will soon reach the one hundred mark, students from the three Michigan schools and those students from other schools who are affiliated in Michigan helped to swell the attendance, so that the meetings closely resembled those of our National Association of not too long ago.

Outstanding speakers at the spring meeting were Dr. Louis S. Lipschutz, Clinical Director of the Wayne County General Hospital, who spoke on "New Trends in Psychiatry." The unusual approach and stimulating ideas which he presented were applicable to all therapists. Dr. Matthew Pilling, of Harper Hospital, gave a most interesting illustrated talk on "Plastic Surgery," showing work being done to restore distorted and wounded features following severe trauma or disease.

The banquet that evening was held at the Detroit Medical Hospital. Mr. John Glendenning spoke on "The Contribution of Occupational Therapy to Vocational Rehabilitation."

Saturday's sessions were held jointly with the Physiotherapy group and proved most helpful. Dr. Max Newman, Chief of the Physical Medicine Section at Grace Hospital, presided at the meeting. Dr. William H. Blodgett of the Detroit Orthopedic Clinic spoke on "The Problem of Cerebral Palsy in Relation to Diagnosis." Miss Marcia Shaw, Physical Therapist of the Sigma Gamma Hospital School, with Miss Antje Price, Occupational Therapist from the same school, demonstrated treatment procedures for the tension athetoid and spastic child. Dr. Morton Seidenfeld, Director of Psychological Services of the National Foundation for Infantile Paralysis, spoke on the "Psychological Elements of Poliomyelitis." He stressed the prevention, rather than correction of psychological difficulties, and reminded us that we exist professionally only because of the patient. Captain Felie Clark, Chief Physical Therapist, and Arlene Schram, Occupational Therapist of Percy Jones Hospital, gave a demonstration on the training of amputees in Army General Hospitals. Patients from the hospital and representatives of Vocational Rehabilitation assisted the therapists in the demonstration. The meeting concluded with the showing of the War Department Film on the "Training of the Amputee."

Everyone attending the meeting was fully repaid in knowledge and renewed stimulation she received in her profession through such a well-planned diversified program. Much credit is due Adaline Truax for the splendid program provided.

The second meeting of the Association was held October 10th and 11th at Grace Hospital in Detroit. Following registration and a general business meeting, Dr. Peter Martin, of Pontiac State Hospital, gave an interesting talk on "Shock Therapy." This was followed by a Craft Demonstration on Weaving by Mrs. Nellie S. Johnson. An illustrated lecture on Pneumonectomy by Dr. W. A. Hudson completed the afternoon program. Tea was served by the Wayne University Occupational Therapy Club in Webster Hall.

At the dinner meeting held at the Women's City Club, Dr. Sidney Licht gave a most inspiring talk entitled "New Trends in O.T." All of those who attended left the meeting resolved to contribute something in the way of research.

On Saturday morning, Dr. Licht spoke on "Music in Medicine," which was followed by an interesting demonstration and talk, "Puppets & Marionettes," by Mrs. Fern E. Zwickey.

In addition to these two state-wide meetings, monthly district meetings have been held by the Detroit, Pontiac, Ypsilanti and Kalamazoo groups.

Problems relating to Civil Service and matters of national importance have been discussed at various meetings. A number of new departments have been developed in the state during

this past year with an increase in eligible active membership. A substantial amount of publicity pertaining to the 25th Anniversary of the Kalamazoo school has been the means of stimulating more interest among high school and college students in the profession of occupational therapy.

OFFICERS

President—Mrs. Leila Wilkins, O.T.R., Pontiac State Hospital.

Vice President—Adaline Truax, O.T.R., Herman Keifer Hospital, Detroit.

Secretary—Doris Ellenbecker, O.T.R., Ypsilanti State Hospital.

Treasurer—Mrs. Katherine Habel, O.T.R., Kalamazoo State Hospital.

Delegate—Marion R. Spear, O.T.R., Western Michigan College.

KANSAS

Delegate Reporter: Myrl Anderson, O.T.R.

The K.O.T.A. has held one meeting since last reporting to A.J.O.T.—this was a November luncheon meeting in Lawrence, Kansas, to hear the Delegates' report of the 1947 annual convention of the A.O.T.A. Recommendations and actions of the House of Delegates were heard and discussed; also reports of the conventions program in general.

In order to revise the K.O.T.A. constitution to conform with recommendations made by the House of Delegates, a committee was appointed by the president to take action on the matter. Members of this committee are Myrl Anderson, Louise McMillan and Ila Patterson.

Present membership in the K.O.T.A. numbers thirty-two. This includes persons from allied fields who are interested in the development of occupational therapy. Members are located in various sections of the state, which makes it difficult to meet together as often as is desirable.

OFFICERS:

President: Miss Bell Stewart, O.T.R., Veterans' Hospital, Wadsworth.

Vice-President: Miss Nancy Greenman, O.T.R., University of Kansas, Lawrence.

Secretary Treasurer: Mrs. LaVerna Wallace, O.T.R., 4132 Wyoming, Kansas City 2.

Delegate: Miss Myrl Anderson, O.T.R., Menninger Foundation, Topeka.

Alternate: Mrs. Nina Crawford, O.T.R., University of Kansas Hospital, Kansas City.

NORTHERN CALIFORNIA

Delegate Reporter: Mary D. Booth, O.T.R.

The Northern California Occupational Therapy Association holds five meetings a year. The first meeting was a picnic at the ranch home of Miss Mary Rixford, in Los Altos, California. This was primarily a social gathering to welcome new members. The second meeting was held at the Rehabilitation Center to which Miss Hazel Furscott and Miss Ruth Miller welcomed us. Dr. Ralph Soto-Hall, orthopedic surgeon, spoke on the history of rehabilitation and we came away with a conviction that we might profit from the example of the Greeks and the Egyptians at least as far as beauty of environment and variety of activities is concerned.

In December, Miss Meryl VanVlack, Occupational Therapist, Veterans Administration Branch Office, spoke on the Veterans Rehabilitation Program with special emphasis on the occupational therapy program. We ended up with a stimulating discussion of patient ratio to occupational therapy personnel. The Veterans Administration Hospital at Fort Miley, San Francisco, was host.

On February 13, 1948, a meeting on occupational therapy with the cardiac patient was presented at the Handicapped and Crippled Children's Guild in Oakland. Dr. Dimler on the staff of the Children's Hospital of the East Bay presented the Physicians' Approach and Miss Margaret Rood, Director of Occupational Therapy at the University of Southern California, presented the occupational therapists' approach.

The annual meeting will be held at the Hassler School in Redwood City. The cerebral palsy patient will be the topic for discussion.

The meetings have been enthusiastically attended by 30 or 40 occupational therapists and their guests, including doctors, social workers and nurses. Our big problem is to break up the social hour which follows each meeting.

OFFICERS:

President: Gwen Wright, O.T.R., Stanford Convalescent Home, Palo Alto.

Vice-President: Henrietta Kleinschmidt, O.T.R., Veterans' Hospital, Palo Alto.

Secretary-Treasurer: Evelyn Moose, O.T.R., El Portal School for Cerebral Palsied Children, Milbrae.

Delegate: Mary D. Booth, O.T.R., San Jose State College, San Jose.

NEW JERSEY

Delegate Reporter: Naida Ackley, O.T.R.

The N.J.O.T.A. held three meetings during 1947. The annual meeting was held at the Veterans Hospital, Lyons, N. J., in March. The members enjoyed a tour of the Rehabilitation Facilities and the program, planned by Mrs. Gail Fidler, O.T.R., Chief O.T., was given by the Medical Reconditioning Staff of the hospital. The account of the services and coordination that are necessary for a unified rehabilitation program in a large V.A. hospital was extremely interesting to the therapists from civilian hospitals.

Another meeting was held in Trenton in June, at which Mrs. Berenda Abrams O.T.R., Dir. O.T. at the Betty Bacharach Home, Longport, N. J., Miss Mildred Schwagmeyer O.T.R., Dir. O.T. at the Bonnie Brae Sanitorium, Scotch Plains, N. J., and Miss Helen Morphy O.T.R., Lyons Veterans Hospital, spoke on the practical application of O.T. in their respective fields.

The third meeting was held in Newark in October. As a result of this meeting Miss Naida Ackley was dispatched to the Convention as one of the most thoroughly instructed delegates of all time. Mrs. Fidler, Chairman of the Fund Raising Committee, also conducted an auction of articles brought by the members.

During the year the N.J.O.T.A. has made a concerted effort to enhance its value as a professional organization, particularly in its programs, and to this end has raised its dues for Active Members to $3. Full minutes of each meeting and program have been sent to all members, and this has proved so popular that it will undoubtedly be continued.

The Association has also been actively engaged in bringing to the attention of the State authorities the salary situation of O.T.'s in New Jersey. This is a matter which seems peculiarly the province of the Association, since so many of the O.T.'s in New Jersey are employed by the state or local governments and since equitable salary ranges in one area tend to help all.

A committee has also been appointed to revise the N.J.O.T.A. constitution in accordance with the findings of the Committee on Credentials of the House of Delegates of A.O.T.A., and the new constitution came up for ratification at the annual Meeting, March 10, 1948.

The N.J.O.T.A. now has 64 members.

OFFICERS:

President: Mrs. Leonore Carpenter, O.T.R., State Hospital, Trenton.

First Vice-President: Mrs. Gail S. Fidler, O.T.R., Lyons Veterans Administration Hospital.

Second Vice-President: Ethel E. Huebner, O.T.R., Trenton State Hospital.

Secretary: Miss Phyllis Greenwood, O.T.R., Lyons Veterans Administration Hospital.

Treasurer: Miss Patricia Williams, O.T.R., The Community Hospital of Northern Valley, Englewood.

SPECIAL GROUPS

U. S. PUBLIC HEALTH

Editor, A. William Reggio, M.D.

Bridging the gap between rehabilitation facilities and rehabilitation needs for disabled Americans will be a leading topic of the National Health Assembly, Oscar R. Ewing, Federal Security Administrator, has pointed out in announcing the formation of a rehabilitation section of the Assembly.

The Assembly, to be held in Washington, D. C., May 1-4, was called by the Federal Security Administrator in response to a message from the President to Mr. Ewing requesting him to develop feasible national health goals for the next 10 years.

Dr. Henry H. Kessler, eminent orthopedic surgeon of Newark, New Jersey, who heads the Rehabilitation Committee of the American Medical Association's Council on Industrial Health, will be chairman of the rehabilitation section. A committee of not less than five experts in the field of rehabilitation will assist Dr. Kessler in the work of the section.

The rehabilitation section will be composed of about 40 professional and lay people. They will be men and women who are authorities in the fields of medicine, rehabilitation, and social work and welfare; experts having a special interest in severely handicapped groups such as the blind, the deaf, and the tuberculous; and industrialists, publishers, and others who have an interest in the subject matter of the section.

The specific agenda of each section of the Assembly will be formulated at the first session of the section. For the rehabilitation section, the discussions may cover the broad topics of

existing facilities for restoring disabled persons to their fullest physical, mental, social, vocational, and economic usefulness; the extent to which the need is not being met; and appropriate means for providing services which are not at present available from public or private sources.

VETERANS

Conference of V.A. Chiefs of O.T.

The chief occupational therapists from 19 Veterans Administration hospitals that had been selected for clinical training of occupational therapy students, and the occupational therapists from branch offices held a conference at the Hines VA Hospital, Chicago, December 8-13. The theme of this conference was training, and Dr. W. T. Doran, from the Department of Medicine and Surgery, Central Office, opened the session with an indoctrination into the Veterans Administration policies for training.

Several evening sessions were held, and approximately 25 exploratory studies and research problems were assigned; and there is promise of reports on June the First. It is be hoped that these studies will prove beneficial to all therapists in the various fields.

Consultants and chiefs of services from Chicago Branch Office and Hines Hospital talked on the various fields of medicine and the relationship of occupational therapy to each. Each gave a 15 minute talk which was followed by a discussion period of 45 minutes. In the period following this an occupational therapist with experience in this field gave the theory of occupational therapy as applied to this field of medicine, and again general discussion was held.

All services—Nursing, Social Service, Special Services—found in a hospital were allocated 30 to 60 minutes and each brought information of great value to the group. Dr. L. B. Newman, Chief of Physical Medicine at Hines, was most generous of his time and presented many pertinent aspects of rehabilitation. Members of Dr. Newman's staff presented the coordination of all sections of physical medicine rehabilitation.

Dr. H. Worley Kendell, President of the American Congress of Physical Medicine, spent several hours at the meeting. Directors of occupational therapy schools who participated in the programs were Miss Beatrice Wade, University of Illinois; Miss Henrietta McNary, Milwaukee-Downer College; and Miss Sue Hurt from Washington University School of Medicine, St. Louis, who is also a member of the National Advisory Committee to VA on Occupational Therapy.

Clinical training for students from accredited schools of occupational therapy in selected VA hospitals has been inaugurated under the direction of the Research and Education Service of the Department of Medicine and Surgery. The training centers will augment those established in civilian hospitals and thus make available more trained therapists to fill vacancies in the Veterans Administration.

Students may receive two months' general, medical and surgical, two months' tuberculosis, two months' orthopedic, three months' neuropsychiatric training, or any combination of these fields of training, depending upon assignment by the schools.

Home Economics for Women Patients

Naomi McKenney, O.T.R.

A challenge was presented to the Physical Medicine Rehabilitation staff of the Veterans Administration Hospital at San Fernando, California, regarding the rehabilitation of patients in the women's ward.

Activities stressing technical or academic subjects had been established for male patients so as to assist them in meeting the economic and physical demands of making a living after discharge. Nothing, however, other than leather work and allied activities were available for the women whose profession would be homemaker.

The challenge was met by a planned program of home economics which is now being organized with occupational therapy treatment directed toward jobs common to every home, rather than diversion and "busy work." The patient now learns the use and care of sewing machines and attachments, the use of commercial patterns, mending and the proper care of clothing. Other interesting projects are the making of slip covers and block print draperies.

The occupational therapists have requested the assistance of others in the Physical Medicine Rehabilitation Service. Educational Ther-

apy, responsible for academic subjects, will provide courses in homemaking, budgeting and child care. Manual Arts Therapy can teach the patient how to make minor repairs on household appliances or the proper way to refinish furniture.

Although much of the activity in home economics is arranged primarily for the ambulant and semi-ambulant patient, the program is being started while the patient is still on bed rest. Simple sewing skills are being taught and a homemaking scrapbook of household hints, recipes, and interior decorating started. The resources of the library are very adequate and copies of magazines are available for clipping.

The work of volunteers is facilitating this program. The Arts and Skills Corps of the American Red Cross under the supervision of the occupational therapy department takes charge of the work in ceramics, flower arrangements, and corsages. A course in charm is being presented periodically by a Southern California beauty columnist. This course includes lectures and illustrations in grooming, posture, and cosmetics—stressing the use of style to overcome postural defects such as thorocoplasty.

Although this program of Home Economics might appear on the surface to stress the teaching of skills, the vital importance of graduated exercise and the determination of work capacity is not overlooked. This is to insure to the highest degree possible that the homemaker when returning to her family will know the limitation imposed by her illness and the implication of readmission unless strictly observed.

VALUE OF APPLIED ART

(V. A. Los Angeles, Calif., Neuropsychiatric Hospital)

Mere words might not have broken through their apathy, but a few gay decorations painted on some supply cabinets may prove an important factor in returning a group of patients at V.A. Los Angeles Neuropsychiatric Hospital to useful private life.

The value of art—applied design and interior decoration—in the treatment of certain types of mental patients has long been accepted by doctors but the job of selling it to the patients themselves was another matter. Some called it "fancy work" and wanted none of it.

A former interior decorator, now serving as an occupational therapist at the Los Angeles Hospital found the right approach. She persuaded several patients to help her decorate weaving room supply cabinets with simple peasant designs copied from museum pieces. It wasn't an art project at all, she implied, just a chore that had to be done to enliven the shop. Then she had them decorate the radio cabinets and show cases in the woodshop. Her "sales campaign" was won when one patient remarked: "This is something you see for sale in department stores, something worth good money." There was no more talk of "fancy work."

Practical application of art was impressed on open ward patients still further through special designing and weaving of such articles at wall hangings, table scarves, drapery materials for ward windows and creation of painted window cornices with designs to match the windows.

In the woodshop patients are making boxes, whatnots to hang on the walls, plant holders and decorative plaques. Other patients are being taught the mixing and application of paints, varnishes and wood finishings. The course includes the complete study of interior designs and some phases of architecture, the making of scale drawings and color sketches of interiors for homes, along with the designing and actual making of furniture in miniature to fit miniature scale model interiors and settings.

It is felt that in cases where patients have a good chance of returning to the workaday world, cured, many may find in this course the start of a successful business career.

Published with permission of the Chief Medical Director, Department of Medicine and Surgery, who assumes no responsibility for the opinions expressed or conclusions drawn by the author.

What to do with putty that has become hard and crumbly: work in linseed oil in small amounts. A good bit of elbow grease is very helpful when kneading the putty.

OCCUPATIONAL THERAPY TRAVEL STUDY GROUP

August 1st—August 24th

This year, as last, the Internation School of Art is offering to students and graduates, a course in Occupational Therapy Travel Study under the leadership of Mrs. Ethel H. Sanford, O.T.R., and Elizabeth C. de Cervantes, Executive Secretary of the school. The craft villages with their metalry, weaving, woodwork and graphic arts may be visited in and around Guadalajara in comfort because the hot days will be behind you. In Guadalajara itself there are the weaving and pottery studios, glass and silver factories to be visited as well as the prison workshops and the orphanage.

Home workshops near Lake Chapala and Lake Patzcuaro will be as interesting to see as the lacquer work and volcano at Uruapan. The fireworks and silverware at Taxco, the floating gardens, the pyramids, and the stores of Mexico City will be visited before the trip is over.

The price of the trip from Guadalajara to Mexico City is $345. Further information may be had by writing to Mrs. Ethel H. Sanford, O.T.R., 11508 Rochester Avenue, Los Angeles, California.

INTERNATIONAL POLIOMYELITIS CONFERENCE

The National Foundation for Infantile Paralysis, with the cooperation of federal agencies and scientific societies, sponsors the First International Poliomyelitis Conference which will be held at the Waldorf-Astoria Hotel in New York City, July 12-17.

Invitations have been extended through the Department of State to more than sixty governments. The official languages of the Conference will be English, French and Spanish. There will be simultaneous interpretation of each address. Proceedings of all sessions including scientific papers and summaries of panel discussions, will be edited and published. Scientific and technical exhibits showing progress in research and treatment, and clinical demonstrations are to be included in the program.

Inquiries regarding the Conference should be addressed to Mr. Stanley E. Henwood, Executive Secretary, First International Poliomyelitis Conference, Room 571, Waldorf-Astoria Hotel, New York 22, N. Y.

EVENTS CALENDAR

MAY 23-28

American Physical Therapy Association, La Salle Hotel, Chicago, Illinois.

MAY 31-JUNE 4

Biennial Convention of American Nurses' Association at Stevens Hotel; National League of Nursing Education at Palmer House; National Organization for Public Health Nursing at Congress Hotel, Chicago, Illinois.

JUNE 21-25

American Medical Association, Chicago, Illinois.

JULY 12-17

First International Poliomyelitis Conference, Waldorf-Astoria Hotel, New York City.

SEPTEMBER 4-11

American Occupational Therapy Association, Hotel Pennsylvania, New York City.

SEPTEMBER 7-11

American Congress of Physical Medicine, Hotel Statler, Washington, D. C.

OCTOBER 18-22

American Association of Medical Record Librarians, Los Angeles, California.

ANSWERS TO O-TEASERS ON PAGE 111

1. Mental hygiene or psychological preparation, social service, morale maintenance, physical therapy, occupational therapy, recreation, education, vocational counselling, physical and vocational rehabilitation, the will to get well.
2. An attempt to create normal experiences to meet the needs in the child's intellectual, emotional and motor development.
3. The English Association of Occupational Therapists was formed in 1936.
4. Rheumatic fever.
5. An occupational therapy department may be used as a diagnostic clinic through the medium of finger painting or rendition of various subjects in color (free choice by patient) whereby he may express hidden symbolical meanings of his frustrations or repressions.
6. Dystrophy involves muscles themselves and not the nervous system except secondarily and in the latter course of disease. Probably an abnormality of muscle metabolism.
   Atrophy is associated with the degenerative changes of nerves which are neural in character.
7. Yes.
8. No.

SPECIAL NOTICES

AMERICAN CONGRESS OF PHYSICAL MEDICINE

The Congress is holding its 26th Annual Scientific and Clinical Session from September 7-10 at the Hotel Statler in Washington. A group of 10 lectures is available to registered physical and occupational therapists. The charge for a single lecture is $2.00; for the full schedule, $15.00. For full information and application form, address American Congress of Physical Medicine, 30 North Michigan Avenue, Chicago 2, Illinois.

Tuesday, September 7

10:00-10:50—(1) Principles of Treatment of Rheumatoid and Osteoarthritis

11:00-11:50—(2) Rehabilitation of the Severely Injured

3:00-3:30—(3) Evaluation and Management of Patients with Cerebral Palsy

4:00-4:50—(4) Treatment of Cerebral Palsy

Wednesday, September 8

8:30-9:20—(5) Manipulation—Indications and Technics

9:30-10:20—(6) Manipulation — Indications and Technics

Thursday, September 9

8:30-9:20—(7) Physical Treatment of Fractures

9:30-10:20—(8) Physiologic Basis and Management of the "Shoulder-Hand Syndrome"

Friday, September 10

8:30-9:20—(9) Use of O.T. in Physical Medicine

9:30-10:20—(10) Clinical Application of Muscle Strengthening Exercise

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INTERNATIONAL CONGRESS ON MENTAL HEALTH

Many therapists in psychiatric hospitals are eager to hear more about the program of the International Congress on Mental Health to be held in London in August. Inquiries may be addressed to Dr. Nina Ridenour, Executive Officer, International Committee for Mental Hygiene, 1790 Broadway, New York 19, N. Y.

Clinical Research and Service

Among the plans which are in progress at the moment is a moderate collection of sample forms of prescription cards, progress sheets, and case-study outlines, to be published for distribution at a minimum cost, for the many therapists who desire helpful information on the proper kind of records to improve the effectiveness of their expanding programs. While many departments already have an efficient system of recording their data and case-findings, others are aware of weaknesses in that part of their organizations, and will have an opportunity to take suggestions from such a collection of material.

An invitation is extended to all therapists in the psychiatric field to send in any forms which they are finding adequate for their purposes, if they have not already been solicited. Also, they are requested to write for suggestions on whatever information they are seeking along this line.

It is hoped that an impromptu session for psychiatric O.T.'s may be held during the A.O.T.A. convention in N. Y. C. to discuss informally such questions as "treatment procedure, administration, and clinical training advice for the psychiatric training center."

HALF-YEAR JOURNAL SUBSCRIPTION
(August-December, 1948)

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1948 CONVENTION

Hotel Pennsylvania, New York City

September 4-6 Meetings of Executive Committee, Board of Management, House of Delegates, Standing and other Committees, Special Groups; Tea for officers, delegates, board, and members of committees.

September 7-9 General Sessions; Banquet.

September 10-11 Institute on Neuropsychiatry.

(Watch for Convention Program in the June issue of the Journal)

PERMANENT CONVENTION COMMITTEE

Lucie Spence Murphy, O.T.R., Milwaukee-Downer College, Chairman
Susan Colston Wilson, O.T.R., Brooklyn State Hospital
Marian Davis, O.T.R., Children's Hospital, Los Angeles
Sue P. Hurt, O.T.R., Washington University
Jane Myers, O.T.R., Veterans' Administration
Ruth Robinson, O.T.R., Brooke General Hospital
Margaret Rood, O.T.R., University of Southern California
Wilma L. West, O.T.R., Executive Director, A.O.T.A.

LOCAL CONVENTION COMMITTEE

General Chairman ..... Miss Susan C. Wilson, O.T.R.
Banquet ..... Mrs. Edgar D. Oppenheimer, O.T.R.
Demonstrations and Exhibits ..... Mr. Martin W. Neary, O.T.R.
Extra-Curricular Activities ..... Mrs. Harriet Jones Tiebel, O.T.R.
Hospitality ..... Miss Mildred Spargo, O.T.R.
Institute ..... Miss Elizabeth Smedes, O.T.R.
Printing ..... Miss Julia C. Olivo, O.T.R.
Program ..... Miss Frieda J. Behlen, O.T.R.
Publicity ..... To be appointed
Registration ..... Mrs. Blanche M. Ringel, O.T.R.
Round Tables ..... Miss Marguerite Abbott, O.T.R.
Transportation ..... Mrs. Evelyn Joseph, O.T.R.

Western New York Occupational Therapy Association to be Co-Host

The Western New York Occupational Therapy Association is sharing, with the New York State Association of Occupational Therapists, responsibility for arranging the 1948 Convention.

Mrs. Mary B. Satterfield, O.T.R., Director of Occupational Therapy, Clifton Springs Sanatorium and Clinic, Clifton Springs, N. Y., is President of this up-state group, some of whose members are on the program. Other members will help with registration, serve as hostesses and provide decorations for the banquet.

The two New York associations will be co-hosts at a tea for the officers, delegates and members of the board and committees on Monday afternoon, September 6th.

Members, make your rail or air travel reservations to New York as far in advance as possible! Remember Labor Day holiday is one of the heaviest traffic periods of the year in the New York-New England area. Then, too, this is New York City's Golden Jubilee Year and many additional and unusual attractions will be offered so the demand for accommodations will reach an all time peak.

A trip to the United Nations at Lake Success via chartered bus is being planned for Thursday, September 9th. Depending on the schedule of the U.N., arrangements are being made so that our members will have an opportunity to attend a session. Reservations for admission to U.N. sessions must be made far in advance.

FIELD TRIPS
Thursday, September 9

INSTITUTION	NO. VISITORS	TIME
N. Y. C. Cancer Institute		1:30- 4:30
Goldwater Memorial Hospital (chronic)		1:30- 4:30
City Home for Dependents (geriatrics)		1:30- 4:30
Hospital for Joint Diseases	15-20	1:00- 4:00
N. Y. State Psychiatric Institute and Hospital	60-80	1:30- 4:30
Payne Whitney Psychiatric Clinic of New York Hospital	25	3:30- 4:30
National Hospital for Speech Disorders	25	2:00- 5:00
Altro Workshops, Inc. (rehabilitation)	50-60	1:30- 5:00
U.S. V.A. Rehabilitation Center		

— Ray Clinic		1:00- 4:00
City Hospital (general)		1:30- 4:30
UNITED NATIONS		1:15- 6:00

Friday, September 10

INSTITUTION	NO. VISITORS	TIME
Altro Workshops, Inc. (rehabilitation)	50-60	1:30- 5:00
Bellevue Hospital (general—special emphasis on rehabilitation)	30	10:00- 4:00 (no lunch)
Brooklyn State Hospital (psychiatric)		1:30- 5:00
Hospital for Joint Diseases	15-20	1:00- 4:00
N. Y. Service for Orthopedically Handicapped—School for C. P. Children	8- 9	9:00-12:00
Triboro Hospital (tubercular)		1:30- 4:30
City Hospital (general)		9:30-11:30
City Home for Dependents (geriatrics)		9:30- 4:30
Goldwater Memorial Hospital (chronic)		9:30- 4:30
N. Y. C. Cancer Institute (Lunch may be obtained at a diner on Welfare Island where Institute is located)		9:30- 4:30
N. Y. State Reconstruction Home, West Haverstraw, N. Y. (orthopedic) (via bus, ferry and train, one hour by auto from city)	20-25	1:30- 4:30
Letchworth Village, Thiells, N. Y. (psychiatric—mentally defective) (via bus, ferry, train and taxi. Two miles out of West Haverstraw. Lunch for small group)		8:00- 4:00
Bridgeport Rehabilitation Center, Inc., Stratford, Connecticut (via train and bus. Two-hour drive by auto. Lunch provided at visitors' expense. Shops open to 4:00; Employment Room to 4:30)		8:30- 3:30
Fairfield State Hospital, Newtown, Connecticut (psychiatric) (via train and bus. Two and a half hour drive by auto. Lunch if notified in advance)	10	1:30- 3:15
The Seeing Eye, Inc., Whippany, New Jersey (blind) (one and a half hours by bus, forty-five minutes by auto)	20	2:00- 3:30

CONVENTION FEES

Note that registration fees to A.O.T.A. members have been reduced to $4.00.

The charge for the banquet will be $5.85. It is thought that by holding the traditional school get-togethers at the banquet on Wednesday, September 8, students and alumnae can enjoy their annual reunions as in former years, yet save the cost of the additional luncheon. Tables will be reserved for each school, according to arrangements made with

Mrs. Edgar D. Oppenheimer
1148 Fifth Avenue
New York 28, N. Y.

and ample provision will be made for alumnae of discontinued schools and persons preferring to attend the banquet in private parties. The after-dinner program promises to be inspiring and to insure a memorable evening.

AMERICAN CONGRESS OF PHYSICAL MEDICINE

We wish to point out that the American Congress of Physical Medicine will be meeting at the Hotel Statler in Washington on dates which coincide with those of our convention. Therapists who have not attended meetings of this group will want to find time to avail themselves of the opportunity, not only to visit the nation's capital, but to become acquainted with some of the members of the Congress who have been so instrumental in the advancement of our profession.

Washington has one of the most modern airports in the world, and a plane will take you to it from New York in an hour and a half. By car it is approximately 230 miles; by coach train, three and a half hours at a cost of $6.46 one way.

Watch the *Archives of Physical Medicine* for the Congress program.

Department of Utter Frustration

Still another attraction competing for the attention of A.O.T.A. members attending the 1948 Convention will be New York's Golden Jubilee to be celebrated August 19 to September 20 at Grand Central Palace. Something you shouldn't miss will take place there every day.

RESERVATION for INSTITUTE

To be sent to Miss Elizabeth Smedes, O.T.R., Institute Chairman
Address: Box 695, Stonybrook, L. I., N. Y.

Please find enclosed check for $7.50. Please insure my place at the Institute on Neuropsychiatric Conditions following the AOTA Convention, Sept. 10 & a.m. of Sept. 11.

Name .....

Mailing Address .....

City ..... Zone ..... State .....

The Institute fee is separate from hotel expenses. If you prefer to pay this fee at the time of registration, but expect now to attend the Institute, send the above coupon to Miss Smedes after crossing out the first sentence.

COUPON for the CONVENTION COMMITTEE

To be sent as soon as possible to Miss Susan Colston Wilson, O.T.R.
Local Convention Chairman, 681 Clarkson Ave., Brooklyn 3, N. Y.

I will attend the AOTA Convention at HOTEL PENNSYLVANIA, New York, arriving

on .....

I (will) (will not) attend the Institute on Neuropsychiatric Conditions.

(Institute all day Sept. 10; a.m. only Sept. 11, 1948)

Signature .....

Mailing Address .....

City ..... Zone ..... State .....

This coupon is to help the Convention Committee, and does not take the place of the Hotel Reservation Form nor Institute Reservation Form (above). Hotel Reservations should be made with the Hotel Pennsylvania, New York 1, N. Y., direct.

Registration fee for the Convention $4.00 to Members; no fee to non-members. Registration fees are payable Sept. 7, 1948.

A FEW "MUSTS" OF NEW YORK

Statue of Liberty
Guided tour—ferry ride to Bedloe's Island.

Staten Island Ferry Ride
New York City skyline, harbor, view of Statue of Liberty.

Empire State Building
Tallest in world—observatories 1,250 feet above New York City.

National Broadcasting Company
Guided tour—broadcast and television operations—rehearsals.

Rockefeller Center
Guided tour—"City-in-a-city."

Cruise around Manhattan
Guided tour on sightseeing yacht.

La Guardia Airport
View planes from promenade arriving and departing from and to all parts of the world.

Cathedral of St. John the Divine
Will be largest Gothic cathedral in world.

The Cloisters
Medieval art and architecture—part of the Metropolitan Museum of Art.

St. Patrick's Cathedral
Gothic design like cathedral of Cologne.

Temple Emanu-El
Noted for beauty and design.

New York Public Library
One of world's great libraries.

Grant's Tomb
Memorial overlooking the Hudson.

Bronx Park
Botanical Gardens, and Zoo.

Hyde Park
Guided tour—home, grave, library and birthplace of Franklin D. Roosevelt.

United Nations
Cynosure of the whole world.

Chinatown
Guided tour, Chinese opera.

Other Locales
Greenwich Village, Harlem, Broadway, Bowery, Armenian Quarter, Lower East Side, Washington Market.

Historical Spots
Wall Street, Peter Stuyvesant Church, Poe Cottage, Jummel Mansion, Theodore Roosevelt House, Bowling Green, Fraunces Tavern.

Museums
Metropolitan Museum of Art, Museum of the City of New York, American Museum of Natural History, Hayden Planetarium, Museum of Modern Art, Museum of American Indian, Morgan Library, and New York Historical Society Gallery and Museum.

Colleges and Universities
Columbia University, Fordham University, Barnard College, Teachers College, Hunter College, College of the City of New York, New York University.

Our "Musts" for you to see are dwarfed in view of the limitless trail of prospects awaiting you in New York!

In the hubbub of Broadway, the Pepsi-Cola Center (which is truly an oasis) extends its services to our members. This includes any information pertaining to the city, broadcast tickets and student coupons for concerts. From its lists one can get a quick view of every activity of the moment.

Advance reservations for theater tickets, with an additional service charge of seventy-five cents per head, can be made through:

Mrs. Grace E. Batchelder
Batchelder Service Bureau
51 East 42nd Street
Room 606
New York 17, N. Y.

Reservations can also be made with any well-known ticket agency.

Your Convention Committee is anxious to do anything and everything possible to make your visit one that you will long remember. You are urged to cooperate by making all reservations early and by sending notifications for special requests to attend radio broadcasts, special tours, United Nations, field trips or other points of interest to your Chairman of Transportation:

Mrs. Evelyn Joseph, O.T.R.
c/o S. Haines
931 Fox Street
Bronx 59, N. Y.

DID YOU KNOW THAT . . .

You can deduct the following Convention expenses from your 1948 Income Tax Return (amended)?

Transportation to and from convention city.
Hotel and meals during convention.
Registration and other professional fees (includes Institute).
Books or other literature or apparatus for professional use.

Proof of actual attendance at the Convention satisfactory to your local Collector of Internal Revenue must substantiate your claim. Take deductions under MISCELLANEOUS, page 3, Form 1040.

RESERVATION FOR HOTEL ROOM

Send to Mr. James R. McCabe, Manager, Hotel Pennsylvania, New York 1, N. Y.

Dear Mr. McCabe:—Please reserve accommodations as checked (√) below:

Name .....
(Please print)

Address .....

City ..... Zone ..... State .....

Unless requested otherwise, the hotel will hold reservation until 9 p.m. of the day of your arrival.

Date Arriving ..... Hour ..... a.m. p.m.

Room and Bath			6.00 ☐
for One	4.00 ☐	5.00 ☐	6.50 ☐
Per Day	4.50 ☐	5.50 ☐	7.00 ☐
Double-Bed Room			8.00 ☐
with Bath	6.00 ☐	7.00 ☐	8.50 ☐
For Two—Per Day	6.50 ☐	7.50 ☐	9.00 ☐
Twin-Bed Room			10.00 ☐
with Bath	7.00 ☐	8.50 ☐	11.00 ☐
For Two—Per Day	8.00 ☐	9.00 ☐	12.00 ☐
SUITE			14.50 ☐
Living Room, Bed Room and Bath		13.50 ☐	16.50 ☐

MORE THAN TWO PERSONS IN ONE ROOM

For each additional person in Double or Twin-Bed Room the extra charge is $2.00 per day.

If a room at the rate requested is unavailable, reservation will be made at the next rate.

1948 Convention of the American Occupational Therapy Association

RESERVATION FOR GUIDED TOUR TO U.N.

To be sent to Mrs. Evelyn Joseph, O.T.R., Transportation Chairman, c/o S. Haines, 931 Fox Street, Bronx 59, New York

RESERVATION FOR GUIDED TOUR TO U.N., Lake Success, N. Y., via chartered bus. Thursday, September 9. Leave hotel 1:15—return hotel 6:00. $2.75 Inclusive.

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